15.0303.03000

FISCAL NOTE

Requested by Legislative Council
02/23/2015

Revised
Amendment to: HB 1041

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1041 requires the Department to issue a request for proposal for the health insurance component and a proposal for the pharmacy component of Medicaid Expansion.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan who contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model. The fiscal impact for this bill is undeterminable.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 02/24/2015

15.0303.02000

FISCAL NOTE

Requested by Legislative Council
02/23/2015

Revised
Amendment to: HB 1041

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1041 requires the Department to issue a request for proposal for the health insurance component and a proposal for the pharmacy component of Medicaid Expansion.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan who contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model. The fiscal impact for this bill is undeterminable.

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Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 02/24/2015

15.0303.02000

FISCAL NOTE

Requested by Legislative Council
02/23/2015

Amendment to: HB 1041

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	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1041 requires the Department to issue a request for proposal for the health insurance component and a proposal for the pharmacy component of Medicaid Expansion.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan who contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model. The fiscal impact for this bill is undeterminable.

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C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 02/24/2015

15.0303.01000

FISCAL NOTE
Requested by Legislative Council
12/19/2014

Revised
Bill/Resolution No.: HB 1041

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$50,000		$106,080
Expenditures			$50,000	$50,000	$106,080	$106,080
Appropriations			$50,000	$50,000	$106,080	$106,080

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1041 requires the Department to issue a request for proposal for the health insurance component and a proposal for the pharmacy component of Medicaid Expansion. It also requires an annual audit of the Pharmacy Benefit Manager's services if the pharmacy component is not provided by the Department.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan who contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model. Section 1 subsection 3b establishes reporting requirements of the PBM which includes an annual audit. The fiscal impact above only represents the additional expenditures incurred to have an audit performed and these expenditures will only be incurred if the department does not provide the pharmacy component internally. The department is anticipating one audit occurring in 15-17 and two audits occurring in the 17-19 biennium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The Department will be able to access federal Medicaid funding of $50,000 for the 15-17 biennium and $106,080 for the 17-19 biennium.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

If the pharmacy services are not provided by the Department, the Department would anticipate one audit in the 15-17 biennium increasing expenditures by $100,000 of which $50,000 would be Federal funds and $50,000 would be General Fund. In the 17-19 biennium expenditures will increase to $212,160 of which $106,080 will be Federal funds and $106,080 will be General Fund, providing for an annual audit in each year of the 17-19 biennium.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

If the pharmacy services are not provided by the Department, the Department will need an appropriation increase for the 15-17 biennium of $100,000 of which $50,000 will be Federal funds and $50,000 will be General Fund. The Department will need an appropriation increase for the 17-19 biennium of $212,160 of which $106,080 will be Federal funds and $106,080 will be General Fund.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/09/2015

15.0303.01000

FISCAL NOTE
Requested by Legislative Council
12/19/2014

Revised
Bill/Resolution No.: HB 1041

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2013-2015 Biennium		2015-2017 Biennium		2017-2019 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2013-2015 Biennium	2015-2017 Biennium	2017-2019 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

SB2043 requires the Department to issue a request for proposal for the health insurance component and a proposal for the pharmacy component of Medicaid Expansion. It also provides reporting requirements of the Pharmacy Benefit Manager is the pharmacy component is not provided by the Department.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan who contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model. The fiscal impact is undeterminable.

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Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/02/2015

2015 HOUSE HUMAN SERVICES

HB 1041

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1041
1/12/2015
Job #21849

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Pharmacy benefit management services for the Medicaid expansion program.

Minutes: Testimonies 1-4

Chairman Weisz opened the hearing on HB 1041.

Brendan Joyce: PharmD, Administrator of Pharmacy Services for Medical Services in the DHS gave information on the bill. (See Testimony #1)

Chairman Weisz: Your comment on all prescriptions and the drug use review board's prior authorization program will be followed; are you saying that might not be the case?

Joyce: When the legislation passed in 2013, we were directed to have a private sector solution for the Medicaid expansion. When we did the contract with the MCO we did not require them to follow Medicaid's formulary. They are free to manage the care of their patients as their own manage care organization.

Chairman Weisz: Can you give us an insight on the fiscal note?

Joyce: Under 3b if the pharmacies are not provided by the department, then an appropriation would be needed; specifically only for the audit portion of the bill.

Chairman Weisz: The only cost reflected in that fiscal note is strictly the cost of the audit. There was no estimation of costs being higher or lower.

Joyce: That is correct.

Rep. Kasper: Representative from District 46 in Fargo explained HB 1041. Chairman Keiser has asked me to explain the bill's origin from our interim health care reform review committee. This bill deals with the change of obtaining information from pharmacy benefit managers. It has to do with the Medicaid expansion program. The legislature chose to use private insurance companies. Health insurance's bid and the pharmacy benefit management (PBM) is part of the contract and it is a closed contract. On the interim

committee I asked the question, "what is the cost of the pharmacy spent"? We were told, "We can't tell you because it is proprietary". The interim came up with HB 1041. Insurance companies have two sides. One is the health insurance that pays for the doctor, provider, nurses, surgery and so on. The second side is pharmacy side. In self marketing plans the two are separated because we want transparency. This bill says, when DHS bids the contract for Medicaid expansion, (read page from the bill, page 1 starting at line 19 through line 24). Currently the DHS manages the drugs and the record keeping with Medicaid and have been for years. There would be no extra F.T.E.'s or cost if the department took the pharmacy part of the Medicaid expansion program in-house. In the pharmacy side there are hidden opportunities for profit, that if you do not have transparency they are never disclosed. First area is a rebate. The rebate is the drug manufacturers make pills. The pharmacy managers of the PBM's pay the bill so they are the record keeper in the middle. They also dispense the money so the PBM's are in negotiation with the manufacturers for rebates. They obtain a percentage of the drug spend with that manufacturer on an annual basis. The rebate needs to be exposed and in our case it is not and we do not know if there is a rebate or not. Second, a rebate could be provided to an employer if the contract with the PBM says that. The rebate could go to the insurance plan or could go to the employer. This bill says the bids can be split and when the DHS sees the bids they can look at what their cost would be to manage the pharmacy benefits inside for the Medicaid expansion and they can choose. The rebates can be negotiated and could come to the state of ND or wiped out entirely. When a customer pays the pharmacy, PBM charges the plan a little more than what the customer pays and that is called the spread and that money can be kept by the PBM. Sometimes the PBM will share the spread pricing. This bill gives us the right to know what are the costs and hidden costs behind the scenes.

19:00
Chairman Weisz: The department suggested a start date for January 1, 2017. Would you have a problem with that?

Rep. Kasper: No it is fine with me.

Chairman Weisz: Is there an issue if it is split half and half? For example if the department takes over the pharmacy portion versus the private carrier handling the heath portion?

Rep. Kasper: The insurance companies should have no problem with the split of the PBM; so long as the insurance companies are given the information that they need to make sure the patient has the care they need and they know what drugs they are taking. The insurance carriers are not the PBMs, they are a separate entity.

Mike Schwab: Executive Vice-President of the ND Pharmacists Association testified in support of the bill along with an amendment suggestion. (See Testimony #2)

Lisa Carlson: Director of Planning and Regulation at Sanford Health Plan. I am not in opposition, but I want to shed some light on the process that Rep. Kasper talked about. Sanford Health Plan this summer at the July 23 Health Care Reform Committee Hearing meetings talked about how the Medicaid expansion program was going. We used the existing contracts because there was no time to design new ones. Sanford has heard from

the Pharmacy Association and pharmacies about their concerns with the payment and reimbursement. The results of the meeting with the Department of Human Services was they directed Sanford Health Plan to create a working group, which we did and many meetings with Mike Schwab, Rep. Kasper and others. The result was a four prong solution Sanford Health Plan does not own their own PBM and does not make any money on the PBMs. The Sanford Health Plan moved the whole Medicaid line of business to new network within the pharmacy express grips plan. The result was an escalated reimbursement rate. Next we dealt with our sole community providers and moved them to a custom network. We worked with Mike Schwab and the ND Pharmacy Association signed a memorandum of understanding with them and created a patient engagement program. This program will compensate pharmacists who participate using the ND Pharmacy Association. We cut checks directly to the pharmacist. The last thing we addressed was transparency. We put together a proposal for the state and CMS of a new contract. It is a fully pass through transparent contract to the state. It sets a new floor rate for all Medicaid expansion participating pharmacies. This floor rate will be disclosable. Sanford does get a share of the spread with our PBM.

35:05
Rep. Porter: Talk about the audit component inside of this.

Carlson: There is a deeper dive into the audit of vendors that currently exists. The state is accessing the pharmacy through our contract and that would require a change from our contract with our vendor.

Rep. Fehr: You express some concern that if the pharmacy component was split out that your nurse managers may not have information in real time. Could explain that further and is there anything with the bill we could change to accommodate you?

Carlson: The state already addressed the timing of it. Our concern is that we have real time access. The January 1, 2017 effective date should allow us enough time to build interfaces with the new PBM to ensure we have the real time data.

Jack McDonald: Appeared on behalf of Prime Care Therapeutics with a neutral position. (See Testimony #3)

Rep. Porter: If the department is also bidding and using their current Medicaid structure as a component of this; are you providing all your information to your competitor which would be the State of ND at the same time you are complying with this law?

McDonald: I read it as the department can choose to do the PBM business itself or it could put it out for a bid. They are going to do it themselves or bid it out.

Rep. Porter: The contract isn't for perpetuity. It is a contract with an expiration date. For the next bid round your competitor will have all of the necessary information to justify their bid of one dollar less that what you need to operate.

McDonald: I suppose that is a possibility.

Rep. Porter: I don't have a problem with the information side of it. The component that splits it is the one that has me wondering. At some point, who you are reporting to and being transparent with becomes your competitor. If the package stays bundled then sharing the information is not an issue.

McDonald: That is a possibility.

Chairman Weisz: Rep. Porter it is not so much that state is a bidder, but they have the information available to know whether they want to do it for less.

Rep. Fehr: What is exactly the proprietary information?

McDonald: Each PBM has a different way to work out their contracts with the pharmacies. The use different formulas and cost benefit ratios. Our understanding was that this is the type of information that has to be submitted under this bill. We thought if our competitors could use this information against us we should have some confidential.

Rep. Fehr: You are saying this information under b, being confidential meaning the department would have, but wouldn't release it, and it wouldn't be public information.

McDonald: That is correct.

Joel Gilbertson: Proposed an amendment. (See Testimony #4)

No Opposition

Chairman Weisz closed the hearing on HB 1041

2015 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1041
2/17/2015
Job #24001

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Minutes: ATTACHMENT #1

Chairman Weisz: We will take up 1041. You have some suggested amendments in front of you. (See Attachment #1) I told the department to draft some of the issues they had with transparency. I had the language removed basically allows the idea of splitting it off and have the department do the pharmacy side or a third party. I thought the legislature was very clear last session that we wanted Medicaid expansion to be a private carrier. I haven't heard anything from anybody that would indicate that we have changed our mind. I think the amendment should take care of that issue. I want Brandon to come forward and talk about the language he has.

Brandon Joyce: The Pharmacy Administrator for ND Medicaid. The department will determine a floor and ceiling price for the reimbursement methodology. We will publish that floor and ceiling price. The PBM which is Sanford at this time will pay any pharmacy anything and anywhere between the floor and the ceiling. We won't be stating what any pharmacy is getting paid, but will state specifically what the maximum and minimum they can get paid. This language (in the amendment) would give us the ability to do that. We have to ensure this is applicable for all provide types.

Chairman Weisz: I have a question about "the reimbursement methodology must be available on the department's website". Isn't some of that proprietary and now you are publishing it?

Joyce: The proprietary point would be any contract that a PBM has with an individual pharmacy. We would not be publishing what any individual pharmacy is getting paid. Other states had issues with. There are times when a PBM will own a pharmacy and then they would have that pharmacy get paid (inaudible) plus 42%. They can pay them a high amount. If you don't define a ceiling, they could get away with paying their own entity a higher amount than anyone else. So that is why we need a floor and ceiling.

Rep. Porter: How would that ceiling be chosen?

Joyce: The ceiling could be chosen by looking at the marketplace or the Medicaid rate that we currently pay. If we would choose the Medicaid reimbursement scale, perhaps that

could be the ceiling. The goal would be to have no issues and no reason to pay a pharmacy more than that.

Rep. Porter: Shouldn't we set it? This will expire in 2017. It will only be in place a year and what will it accomplish?

Joyce: We would take the direction from the legislature.

Rep. Porter: Under the expiration provisions of the expansion program, are we doing ourselves a favor by putting into place something that is effective 2016? When does the current contract run out?

Joyce: The contract is on a reoccurring one year renewal. As for being in effect for one year it will take care of issues we have had in administrating the program. It would still assist in assuring continued access for what we had.

Rep. Porter: What is the anniversary date of the contract?

Joyce: January.

Chairman Weisz: Go on to the next section.

Joyce: For c, d and e we wanted to address other issues we have had. For c we wanted mail order to not be the only option. Under d, Sanford will pay for the medical benefits, but if they somebody trying to get services out of state they will investigate and try to figure out why that person is in Georgia. On the pharmacy side there were many states billing for prescriptions and we asked if they were validating these people who were out of state. We want to make sure they are following up on that. They are not paying for those up front. Express Scripts have the national network. They don't do any prior authorization for prescriptions. We want validation to ensure these people are eligible.

Chairman Weisz: Why do you exclude three contiguous states?

Joyce: We do the same for our fee for service program. There are a lot of people in the Ellendale area will head to Aberdeen and Fargo to Moorhead. Some people need to go to Mayo in the twin cities for treatment and we obviously want to pay for the prescriptions when they are there.

Rep. Rich Becker: On prior authorization, what effect does it have if any if you have a four day trip to Utah and you need prescriptions?

Joyce: There is a federal law that says you have to supply a 72 hour supply for emergencies. There is a state law that says we have to give a five day supply. Under e, the pharmacy wants to tell us that the other insurance paid a negative amount and they can't transmit that to us because we don't accept negative amounts. The process ends up collecting some payment from the patient and that goes directly to the PBM. So there is a higher copayment. We are trying to address this.

Rep. Fehr: Are the mail order prescriptions still subject to the minimum and maximums that are listed?

Joyce: Yes.

Mike Schwab: Executive Director of Pharmacy Association.

Chairman Weisz: Can you expand on the claw back provision in e?

Schwab: Let's say a patient comes in to the pharmacy and the pharmacist goes to judicate the claim; the claim gets kicked back to the pharmacy and it will say the patient copay will be $100. The patient assumes it is $100 and pays it. The provider keeps the copay. Later on the PBM will (inaudible) from future remittances from the pharmacy let's say $75. The pharmacist would end up with $25 even though $100 was paid. That is being coined as a claw back. It is being looked at by a number of states and some are pushing for a whistle blower type situation. We started seeing this in discount cards where the copay would be inflated and the copay would later be taken back from the PBM with no recourse from the pharmacy. We'd also see this at high end or front end deductibles. The patient will reach the donut hole a lot quicker then. It is inflated on the front side, but that was not the real cost.

Chairman Weisz: Do you have any comments on the amendments?

Schwab: It makes sense and we support transparencies. I know Rep. Porter was asking for time frame. It is annually, but could be renewed each year for up to a six year period.

Rep. Porter: I move the amendment.

Rep. Fehr: Second.

Rep. Oversen: The request to change the effective date collated to the original bill? I don't know if the amendment changes that request.

Joyce: This bill ends up repeating what is already in law. The dates remain the same because those are the law dates. If you want this to start 2016, you are going to have to say it somewhere.

Rep. Porter: If you take section 2 of the bill out are we able to change your contract with Sanford Health so they have to comply with the new components of the law? Or, are you bound by the contract terms of the one year until January of 2016?

Joyce: The contract includes provisions that they have to be reactive and comply with any new state or federal laws. It is our standard language because laws do change.

VOICE VOTE: MOTION CARRIED

Rep. Porter: I move we remove Section 2. It would change the current contract to six months earlier since they have that provision.

Rep. Seibel: Second.

Rep. Fehr: I am assuming if the department wants to write some rules, is there going to be an issue with them having rules written by whatever date this takes place?

Rep. Porter: They already have everything in place.

Joyce: We have a good idea where the floor and ceiling will be with the reimbursement methodology. We will defer to the legislature on how you want that process done.

VOICE VOTE: MOTION CARRIED

Rep. Porter: I would be interested in Mr. Joyce's proposed language on how the ceiling is set on the Medicaid and whether or not we add a new section 2 that says, it is the intent of this assembly that it be set as the same methodology used for Medicaid. Something along those lines would fix the floor and ceiling language.

Rep. Fehr: Rep. Porter, what are we trying to fix?

Rep. Porter: If we set the floor and ceiling inside of the law, then that is one less step the department has to do and we are assured that it is at least at the current Medicaid reimbursement system is at.

Rep. Oversen: I wonder if we shouldn't add that instead of a separate section put it in at "a, sub 3" saying "the reimbursement methodology add a minimum must model current minimum and maximum set under Medicaid" or however stated by Rep. Porter.

Joyce: Currently, the issue came up because the reimbursement methodology by the PBM was a lot lower than ND Medicaid. The floor we got to agree to is still less than what ND Medicaid pays and that will go into effect April 1. We had some premium adjustment and it wasn't too much. If we establish one payment rate we would end up raising the premium some more. There may be some entities getting paid more than ND Medicaid payment rates right now. We are privileged to that information right now. We don't know what individual pharmacies make. We probably would set the ceiling a little above the ND current Medicaid payment rate just for the ceiling to be in effect. Setting the ceiling will not affect premiums. There are detriments in establishing one single payment rate.

Rep. Porter: Based on the amendment we adopted you will have to establish those amounts now?

Joyce: Yes.

Rep. Porter: You feel comfortable without adding anything that it will be standard contract negotiations to set that maximum amount just like you did with the minimum?

Joyce: Correct.

Rep. Porter: Then I'm ok.

Rep. Mooney: The second amendment; on line 7 after rebates had "in aggregate". Is that still relevant?

Chairman Weisz: I don't believe so.

Rep. Oversen: I don't think that line is gone. We replaced full and then full comes back on b in the amendment. It needs to be removed through line 6 and move the rest.

Chairman Weisz: Remove lines 4-6.

Joyce: Representative Oversen is correct. In aggregate is perfectly fine.

Rep. Fehr: I motion.

Rep. Mooney: Second.

VOICE VOTE: MOTION CARRIED

Chairman Weisz: I think you have seen the amendment from Mr. McDonald on the proprietary information. He wants language at the end that says, "any information provided to the department under this section shall be confidential, personal" etc. With the new language that we adopted (stops sentence).

Rep. Porter: I move the amendment, but it needs to have an f. I would move the proposed amendment.

Rep. Seibel: Second.

VOICE VOTE: MOTION CARRIED

Rep. Fehr: I Move a Do Pass as Amended on HB 1041.

Rep. Hofstad: Second.

ROLL CALL VOTE: 13 y 0 n 0 absent

Bill Carrier: Rep. Fehr

15.0303.01001
Title.02000

Adopted by the Human Services Committee

2/18/15

February 18, 2015

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1041

Page 1, line 2, remove "; and to"

Page 1, line 3, remove "provide for application"

Page 1, remove lines 19 through 24

Page 2, remove line 1

Page 2, line 2, replace "department, the" with "The"

Page 2, line 2, remove "pharmacy benefit"

Page 2, line 3, replace "manager" with "private carrier"

Page 2, line 3, remove "provide for"

Page 2, replace lines 4 through 11 with:

"a. Provide a reimbursement methodology for all medications and dispensing fees which identifies minimum and maximum amounts paid to pharmacy methodology, at a minimum, must:

(1) Be available on the department's website; and

(2) Encompass all types of pharmacy providers regardless of whether the pharmacy benefits are being paid through the private carrier or contractor or subcontractor of the private carrier under this section.

b. Provide full transparency of all costs and all rebates in aggregate.

c. Allow an individual to obtain medication from a pharmacy that provides mail order service; however, the contract may not require only mail order.

d. Ensure that pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification.

e. Ensure the payments to pharmacy providers do not include a required payback amount to the private carrier or one of its contractors or subcontractors that is not representative of the amounts allowed under the reimbursement methodology provided in subdivision a.

f. Any information provided to the department of human services or any audit firm by a pharmacy benefit manager under this section is confidential under section 44-04-17.1."

Page 2, remove lines 12 through 15

Renumber accordingly

Date: 2-17-15
Roll Call Vote #: 1

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1041

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0303.01001 proposed attach #1

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-17-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1041

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: See below

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Seibel

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Remove section 2 of the bill.

Date: 2-17-15
Roll Call Vote #: 3

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1041

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Fehr Seconded By Rep. Mooney

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Remove lines 4-6

Date: 2-17-15
Roll Call Vote #: 2

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1041

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: See below

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep Porter Seconded By Rep. Seibel

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. Mooney		
Vice-Chair Hofstad			Rep. Muscha		
Rep. Bert Anderson			Rep. Oversen		
Rep. Dick Anderson					
Rep. Rich S. Becker					
Rep. Damschen					
Rep. Fehr					
Rep. Kiefert					
Rep. Porter					
Rep. Seibel					

Voice Vote
Motion Carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

and add an &.

Jack McDonald amendment (in hearing minutes)

Date: 2-17-15
Roll Call Vote #: 5

2015 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1041

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0303.01001

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Fehr Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. Mooney	✓	
Vice-Chair Hofstad	✓		Rep. Muscha	✓	
Rep. Bert Anderson	✓		Rep. Oversen	✓	
Rep. Dick Anderson	✓				
Rep. Rich S. Becker	✓				
Rep. Damschen	✓				
Rep. Fehr	✓				
Rep. Kiefert	✓				
Rep. Porter	✓				
Rep. Seibel	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Rep. Fehr

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1041: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1041 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "; and to"

Page 1, line 3, remove "provide for application"

Page 1, remove lines 19 through 24

Page 2, remove line 1

Page 2, line 2, replace "department, the" with "The"

Page 2, line 2, remove "pharmacy benefit"

Page 2, line 3, replace "manager" with "private carrier"

Page 2, line 3, remove "provide for"

Page 2, replace lines 4 through 11 with:

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b. Provide full transparency of all costs and all rebates in aggregate.

c. Allow an individual to obtain medication from a pharmacy that provides mail order service; however, the contract may not require only mail order.

d. Ensure that pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification.

e. Ensure the payments to pharmacy providers do not include a required payback amount to the private carrier or one of its contractors or subcontractors that is not representative of the amounts allowed under the reimbursement methodology provided in subdivision a.

f. Any information provided to the department of human services or any audit firm by a pharmacy benefit manager under this section is confidential under section 44-04-17.1."

Page 2, remove lines 12 through 15

Renumber accordingly

2015 SENATE HUMAN SERVICES

HB 1041

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/16/2015
24850

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the Medicaid expansion program

Minutes:

Attach #1 Mike Schwab, ND Pharmacists Assoc.
Attach #2 Jack McDonald, Prime Therapeutics
Attach #3 Rod St. Aubyn, PCMA
Attach #4 Robert Harms, CVS Health

Chairman Judy Lee opened the hearing on HB 1041.

Jennifer Clark, Legislative Council**,** introduced HB 1041 to the Senate Human Services Committee. This bill came from the interim Health Care Reform Review Committee. The House hog-housed the bill. The section this amends is the Medicaid Expansion Law. Jennifer Clark reviewed HB 1041 and addressed some missing language and some style changes. The new language deals with the contract, and what it must include.
Lines 20-21, page 1 should state, "...paid to pharmacy providers for each medication. In addition, the reimbursement methodology ..."
On page 2, line 2, right after the first "or", add "the".
On page 2, line 6, she recommended the language to say "....the contract may not require mail order be the sole method of service".
On page 2, line 11, change "that" to "which". (7:10)

Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association, testified IN FAVOR of HB 1041. (Attachment #1)(7:34-8:55) He said they support the engrossed version and they also support the changes that Jennifer Clark presented to the committee for clarification.

NEUTRAL
Brendon Joyce, Pharmacy Administrator for ND Medicaid, Department of Human Services, provided neutral testimony. He said they had provided amendments to the House side, and that is where the majority of the amendments came from.
Line 19, page 1 pertains to provider reimbursement methodology. The reason for this amendment has to do with the issue brought up in the interim with the pharmacy association. There were issues with access as providers were dropping out of ND Medicaid

expansion. CMS requires they ensure there is access. There was concern that they were not getting anywhere with the Pharmacy Benefits Manager. The plan sponsor is Sanford and they are not allowed to know how much the PBM pays the pharmacy. There were also issues where they were asked not to publicize minimum payments. ND Medicaid tends to publicize everything they can so they asked for this to be in the amendment to have the minimums posted as well as the maximums. They want the maximums because they don't want what has been seen in a variety of other entities and PBM relationships where some pharmacies will be paid a higher rate than others. The plan sponsor will pay the PBM for whatever the expense is but the PBM will end up paying their own pharmacy a higher rate than others. It is self-enriching, so they wanted a minimum and a maximum to protect them and to give them a window to where they can state on their website that pharmacies in this Medicaid Expansion Plan will be paid somewhere between top and bottom. If there is a range published, pharmacies will probably want to be reimbursed at the high rate, so that is a down side. Mail order often times is paid differently but just like ND Medicaid, they pay one rate, regardless of type.
Page 2, Line 4 - provide full transparency. There are additional amendments proposed by others regarding this.
Item c - They wanted to insure there was no change or anything in the future that says the pharmacy benefit would be provided by a mandatory mail order. Some plan sponsors do that but ND Medicaid Expansion did not want this to be a mail order only option for the residents of North Dakota.
Line 7, item d - on the medical side, the plan sponsor has a process in place that, if they see someone is getting services in another state, they check to see if that person is a North Dakota resident and still eligible for ND Medicaid. College is the largest issue with this. However, there is a large hole, as the pharmacy side didn't do the same thing. This language is needed to ensure that a patient will not be paid for Medications if they move and live in another state. With Medicaid Expansion a person is deemed eligible and then needs to notify the state if there is a change in residency, income, etc. This is a 12-month certification period.

Chairman Judy Lee asked about the "intent" to be a resident in North Dakota? If I have a Post Office box in North Dakota but live somewhere out of state, could I be covered under the current loophole?

Dr. Joyce said that was his understanding. This would follow the same as medical. He wasn't sure it would solve the issue but it will definitely get it to the same amount of review to the current standards.

Dr. Joyce continued.
Line 10, page 2 e - He pointed out that this is complicated and explained that there were issues where pharmacies have a primary insurance before traditional Medicaid. There are a variety of Office of Inspector General ongoing investigations to see what the impact is to Medicaid nationwide. It is a new process for PBM reimbursement that has been noticed within the last year. They want to make sure the PBM that the plan sponsor is using is not doing this method, and they want full transparency upfront.
Line 10, page 2 f - They want to make sure anything that needs to be confidential remains confidential.

Senator Axness felt there was some contradiction in the amendments. It will be available on the department website, full transparency, and then confidential. How can it be full transparency and confidential at the same time?

Dr. Joyce responded that for the department website, that is only subsection a. The full transparency is that they need to tell how much they are paying out, how much they are paid back. That is in the aggregate type of report and that is something that can be fully out in the open.

Senator Warner asked if there is a bidding process that goes on for this business or an individual negotiation where all the pharmacies get a share of the business but they have different rates.

Dr. Joyce said the negotiation is not done by them, but they are familiar with what occurs. There will be a desire to have network coverage in an area. If there is just one pharmacy, sometimes they are forced to pay more because they need to make sure they get coverage. When it comes to a town like Bismarck, as long as they can get one or two or three and they can provide services in the city, they will be happy to take the lowest bid, and there might be some that aren't contracted.

Chairman Judy Lee stated that the PBM will have a contract with whoever wants to participate in the network so they would have the option of participating or not. But it could still be a big hit to their customer base if they weren't. It is very complicated in setting price.

Dr. Joyce agreed that it is not simple.

Chairman Judy Lee asked, when talking about the minimum and maximums, if there were any discussions in the House committee or Department of Human Services about whether or not there might be a benefit for not just a certain number of drugs but for all the drugs being covered.

Dr. Joyce replied that the reimbursement rate is for all drugs in general. There is a maximum allowable cost list which typically covers generics. They want to essentially give one reimbursement methodology and make it as transparent as possible, predictable and accountable. As of right now the plan sponsor doesn't know what the pharmacy is getting paid. This would end up telling them so they're going to know exactly how much they're paying the PBM for their fees in addition to that. This will have contention on the PBM side.

Chairman Judy Lee asked if the pharmacist could have a contract with the department as a Medicaid payer and then be contracted with others. **Dr. Joyce** indicated yes.

Marnie Walth, Sanford Health, testified NEUTRAL. In reading the bill and having legal counsel review it, she had a question pertaining to section 1-3a which discusses the reimbursement. Does this require reporting the methodology or the reporting of minimum and maximum amounts? It sounds like the intent is the minimum and maximum amounts.

Chairman Judy Lee said that was a good point and then asked if it was her impression that the goal of all the stakeholders is the same or not. Is there a need for clarifying language?

Ms. Walth stated that one common goal is that the pharmacies are paid fairly for their work. As a part of the Medicaid expansion contract, they went back and worked together with the pharmacies to be more fair to all the parties involved, but without legislating.

Chairman Judy Lee said she was not comfy with legislative intrusion in the business relationships.

Ms. Walth had another question. In section 1-3b relating to transparency of costs, their legal council doesn't feel they will have the ability to do that. That's proprietary information. Even in the aggregate.

IN FAVOR of HB 1041
No further testimony

OPPOSITION TO HB 1041
Jack McDonald, Prime Therapeutics, testified in OPPOSITION to HB 1041.
(Attachment #2) (34:50-36:25)

Chairman Judy Lee said there is a problem with out of state expectation for pharmaceuticals that is different from the medical reviews. After hearing from Dr. Joyce, section 3, line 7, page 2, d, Chairman Judy Lee has a personal affection for that section. Since there has been abuse for that provision, that it be vetted the same as medical claims, deserves some attention. It is intended to make sure the requirements for drug claims are looked at in the same way as the requirements are currently in place for medical claims for Medicaid Expansion.

Mr. McDonald pointed out the three contiguous states.

Chairman Judy Lee corrected the "other than". If I went to Mayo, or Billings or Sioux Falls, it is okay. But other states I would need prior authorization. She would like Mr. McDonald to look at that particular provision and see why that would be something to which a PBM would object.

Mr. McDonald asked why they can't do that now.

Chairman Judy Lee responded that they can't do it right now because the requirements for drugs are not the same as medical. Will this make a difference when looking at that particular provision?

Rod St. Aubyn, representing Pharmacy Management Care Association, testified in OPPOSITION TO HB 1041. (Attachment #3)(40:21-51:50)

Chairman Judy Lee was hearing that what she thinks subsection d does and what she was hoping it would do doesn't get done concerning out of state people who are not living

here and who are benefitting from Medicaid expansion coverage of their prescription drugs. She was hoping it would fix a problem.

Mr. St. Aubyn doesn't think it does.

Senator Warner had some sense that this is buyer's remorse. Are we looking at things that should have been negotiated earlier?

Mr. St. Aubyn would say that is probably true. There is nothing that prevents Medicaid or the Department of Human Services from applying this to their specifications.

(53:34) **Patrick Ward**, represents one of the PBMs. He provided testimony OPPOSING HB 1041 from **Mr. Harms** a lobbyist for CVS Health. (Attachment #4) They agree with Mr. McDonald and Mr. St. Aubyn. Pertaining to subsection d questions, he said that Dr. Joyce explained to him what he is trying to accomplish. The PBM's did not understand that was the intent as it was written. Their concern was the interstate commerce clause type of concern and whether this can be enforced on other states or pharmacies in other states. He believes these things can be addressed contractually in the bid proposal. You will not have people want to bid on these contracts as it is written.

There was no further testimony.

The public hearing on HB 1041 was closed.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/16/2015
24880

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the medicaid expansion program

Minutes: No attachment

The Senate Human Services Committee met on March 16, 2015 for short discussion in committee work. **Chairman Judy Lee** voiced her concern regarding the residency issue, and it appears the bill amendments will not resolve that issue. This will require further investigation.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/16/2015
24911

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the Medicaid expansion program

Minutes:

Attach #1: Proposed Amendment Language

The Senate Human Services Committee met on March 16, 2015 to discuss HB 1041 in committee work.

Chairman Judy Lee reviewed the bill and asked for additional information. She requested help from the Department of Human Services. She also invited Michael Schwab to the podium.

Michael Schwab clarified that all pharmacists have the ability to negotiate contracts. In theory that is correct. However, with Medicaid expansion, the opposite happened. During last session and interim, it was stated the pharmacists could negotiate their contracts. A large number of the pharmacies would receive a canned response, "this is the only we have at this time." Many times the pharmacy benefit management services what is perceived as a "take it or leave it" contract. The second point of clarification is in regards to the clawback, which is Section e of the bill. Mr. Rod St. Aubyn indicated it is not an issue. Dr. Brenden Joyce, Department of Human Services, did touch that if this is brought forward, there is a possibility of a breach in contract with the pharmacy(ies) involved. Mr. Schwab provided an example to help illustrate. Typically, with a clawback, a patient can use a discount card. When sent in for adjudication, it comes back instantaneous and it will show the copay is a certain dollar, $100 for example. The patient and pharmacy is assuming it is a $100 copay, and the patient will pay the $100 copay amount. The pharmacist will finish with the patient. The PBM is then automatically taking funds from that copay for future remittances from the pharmacy. So if the acquisition cost of that drug was $25, and the copay was $100, the PBM will redact that amount from future remittances so the pharmacist will have $75 taken out for future remittances. So they are left with $25, when it should have been the $100 copay. The other instance they see this is in high-end deductibles. In this circumstance, the copay is often inflated, and it is automatically taken back again. How that affects the patient the most is the patient hits their maximum then

when they normally would, and so they end up in the donut hole sooner than they typically would have. The reasons we do not discuss the details is because there are attorney generals and OIG's looking at the situation. There are four states looking at the issue from a class action perspective. They are gathering data at this point. There are a lot of attorneys involved with regards to confidentiality provisions and clauses, or retribution to pharmacies. There may not be pharmacies from North Dakota from a whistle blower perspective, but there is some of that taking place as well. Dr. Joyce's example turned the light on to Medicaid - why is this happening where we are getting claims sent to us from pharmacies showing a negative amount. Mr. St. Aubyn stated why are we not talking about what the pharmacies get paid. When recalling the bill from last session, that is one of the provisions that was in the bill. The pharmacists are not afraid to have an explanation of benefits (EOB) after you come to the pharmacy. You get that on the hospital side, but you don't necessarily get that on the pharmacy side in terms of what the pharmacist was paid, what the plan was paid, and what the PBM was paid. They fought this last session. In talking with other board members, there is no problem in disclosing what we are making as long as the other party discloses what they are making. With regards to the comments that a lot of these provisions can be added to the contract or that the Department of Human Services could do this, if the committee needs clarification on this, we would like to know if that is true, and if it is in fact true, maybe the bill is not needed. But if the Department of Human Services is willing to put forward the amendments, obviously we would hope they do put it in the contract if that's the avenue they have available to them. If the PBM's are okay with it being put into the contract, then he is wondering where the issue is for putting it into statute.

Chairman Judy Lee stated she would hate to see the Department of Human Services be the referee between the two sides who are obviously hostile to one another. Chairman Judy Lee voiced her concern that the likelihood of these two sides coming together are slim.

Mr. Schwab explained they did have a task force, and some things were resolved, Giving Sanford Health some credit, they did come to the table as well as the Board of Pharmacy and the Department of Human Services and a few legislators, and some issues were resolved. Part of the problem is that the contract Sanford has with Express Scripts is separate in terms of how it operates with the pharmacies. As much as Sanford may say one thing, the contract with the PBM's state something different. No different than in the interim, we were left with little recourse but to provide some information to the interim committee because our contracts with the PBM specifically state that all pharmacies are prohibited to talk to the plan sponsor directly, as well as using a third party to talk to the plan sponsor. It is not so simple for us to call Sanford unless we want to technically breach the contract.

Senator Howard Anderson, Jr. isn't it true that the state mac list that pharmacies get paid for products is public.

Mr. Schwab responded, based on our legislation passed last session, all mac lists are to be disclosed and updated within 7 days. For Medicaid, Mr. Schwab responded yes, but deferred to Dr. Joyce.

Senator Howard Anderson, Jr. continued. For Medicaid fee, what the pharamacist gets paid is public. Correct?

Mr. Schwab confirmed. The fee is public. However, the MAC pricing list, he does not believe is public. They were asked to be exempt.

Chairman Judy Lee asked for clarification from Dr. Brenden Joyce. Can all of the things that were mentioned earlier by someone who testified that could be part of the contract? Can the Department of Human Services put those things in the contract rather than being part of statute? Some of this is specifics.

Dr. Brendan Joyce, Department of Human Services, we've learned some lessons in the process. We didn't have a managed care contract to any significant degree prior to this. We have learned a number of lessons in how the Request for Proposal (RFP) and contract would be written. All contracts need approval by CMS, and we are working on a contract effective for October 2014 that has not been approved yet. We need another contract effective January 1, 2015. And we'll need another contract down the road. We are getting what provisions we can get put in there as we are able to. There are a number of these provisions that could be put in. The plan sponsor has let us know that certain ones the Express Scripts contractor are not happy with. They do not want some of them. As Rod St. Aubyn eluded to earlier, you may put everything you want in a contract but may not get any bidders on some of them. We still need the network. We still need to have providers that are happy. It is still state dollars. We are essentially having someone pay claims on behalf of us, and we were hoping that we could tell them how they have to pay to some degree, at least give them some guidelines.

Chairman Judy Lee stated since you need CMS approval of all contracts, and this is a continuing thing for the Department of Human Services, wouldn't CMS rules or decisions supersede anything that would be in state statute anyway if it differed from what we might approve in this bill or any other and what CMS say they approve in your contract?

Dr. Joyce stated when talking about CMS, he was explaining the timeline to get something approved through them. CMS won't care so much about the provisions. They are more concerned about the access.

Chairman Judy Lee asked if the contracts are generally two years in duration?

Dr. Joyce indicated that with this contract, we have been somewhat concerned if we try to put some of these provisions in there that we would be asked to re-procure the contract. When we did that after the last session, we worked very hard on it and we still didn't get a contract signed until December 31, 2013. And that was just to get the program launched. Obviously, CMS had a strong interest in helping states get the Medicaid expansion through at that time, and they dedicated tremendous hours to get everything ready for review, such as the RFP, the review of the proposed contract, and the review of the responses. They don't have the resources to continue providing that effort in the same timeframe. At his point in time, if we were to require the provisions we are talking about, there would be some argument for re-procurement.

Dr. Joyce continued. All of the fees are available on a search screen for the mac list. You can type in any medication, and it will tell you exactly what we pay for that medication, whether it is a mac price, or just a calculated acquisition price which is wholesale acquisition price plus 8%. You can search for any given drug at any point in time, including the effective date, and it will tell you what we pay. It is not a list that is published, due to the fact that we have changes every week, so we have no desire to publish a document to the web, but instead have an active file that is available on the web.

Chairman Judy Lee recalled that someone brought up the potential conflict between confidentiality and transparency. Are you comfortable with the way it is being done and not causing an issue for proprietary information?

Dr. Joyce responded for published fees, for Medicaid, we are fully public, so everything is published or available. The exception is drug company rebate to specific with drug-by-drug. We can tell you in the aggregate how much we get like we do in the budget, but we can never tell you how much we get for a specific drug, as that is protected by Omnibus Budget Reconciliation Act of 1990 (OBRA-90).

Chairman Judy Lee further recalled the discussion about minimum and maximum, where the maximum would lead to become the minimum.

Dr. Joyce confirmed this could happen. The other option is to set one rate, and have them pay like a pharmacy benefit administrator. Entities are able to hire not a PBM but a Pharmacy Benefit Administrator (PBA), where they can tell them exactly what it is they want them to pay, and then they just do it. Worker's Compensation follows this method. They stated they want to the AWP minus 10 percent plus $5.00. They had to pay all the pharmacies at that rate.

Chairman Judy Lee asked whether they were rural or urban.

Mr. Joyce confirmed urban, rural, in or out of state.

Senator Howard Anderson, Jr. stated there was some controversy regarding page 1, line 19 and 20, regarding provider reimbursement methodology. Could we replace all that language that with "the Medicaid fee?" You already have that process established.

Dr. Joyce stated they could do this. It is a public fee, and it is already there.

Senator Howard Anderson, Jr. read, "provide and implement the Medicaid fee schedule for reimbursement of all medications and dispensing fees" would replace language on line 19 and 20. Then continue on line 21. This could be alternative language and simplify it for everyone.

Chairman Judy Lee indicated she has additional language handed to her that states, "For specialty drugs, the contract must contain drug-by-drug guarantees that assure that the State is obtaining competitive pricing." I don't think we have even talked about this.

Dr. Joyce indicated this has not been discussed.

Chairman Judy Lee recalled her concern regarding residency eligibility. Obviously she misinterpreted what "d" is in regards to other jurisdictions. This may be the only bill that we can plug some of those holes. We need the opportunity to discuss more whether or not there is some propriety to allow some latitude on changing some eligibility determinations, and do we need statutory authority to do that.

Dr. Joyce remembers the concerns with interfering with interstate commerce.

Chairman Judy Lee stated that was because they were calling for prior authorization other than North Dakota and the surrounding three states. So for Wisconsin and other states, you would need prior authorization, but you wouldn't for Minnesota, South Dakota or Montana.

Dr. Joyce stated that when it comes to the benefit, there is the federal employee plan for instance. If the plan wishes to have prior authorization for a product, they can require prior authorization for a product. It doesn't matter what state the employee works in, nor does it matter what state they get their prescriptions filled in. It is just prior authorization for a product. The medical side for Medicaid expansion requires prior authorization for out-of-state services for that same reason. He cannot imagine how a plan would not be allowed to require prior authorization for something they are paying for. They can do that now, and it shouldn't matter state-to-state.

Chairman Judy Lee asked for medical, it is legal to have prior authorization outside a particular area. So why wouldn't it for pharmacy?

Dr. Joyce agrees - that is the issue.

Chairman Judy Lee asked is there any reason it can't be the same for pharmacy? Is there some stipulation that prescription drugs are going to be?

Dr. Joyce indicated he believes someone was looking too quickly to understand what it is about. Dr. Joyce indicated the intent of this part of the amendment is to fix the disconnect between the medical side and the pharmacy side. The medical side is investigated to see if the person is still a resident of the State of North Dakota when they are getting an out-of-state service. On the pharmacy side, they currently just pay the claim and do not do any investigation at all.

Chairman Judy Lee asked for confirmation that "d" does this.

Dr. Joyce responded yes.

V. Chairman Oley Larsen asked for clarification on Page 2, line 4, it says to provide full transparency of all costs and rebates in aggregate. Were you just saying you can't do that?

Dr. Joyce can provide the information in the aggregate, but not drug-by-drug.

The committee discussed having the suggested changes that Jennifer Clark has provided along with Senator Howard Anderson, Jr.'s language be drafted as a proposed amendment. The intern, Femi, will make the draft changes.

(33:00)
Michael Schwab expressed his support for the bill as presented today with the amendments from the department.

Chairman Judy Lee stated we have three different perspectives here: the pharmacists, the Department of Human Services, and the PBM's. The PBM's have a different view of how to handle this than the pharmacist who is looking at this from another side. And the Department of Human Services is in the middle for Medicaid expansion trying to figure out how to pay for it. All three are important stakeholders.

The intern, Femi, provided a copy of proposed language (attach #1).

Chairman Judy Lee asked if there was any further comment from Mr. Tupa or Dr. Joyce regarding the proposed language. There was no comment from either.

Dr. Joyce commented that if the language for Medicaid fee schedule as adopted, it also takes care of the specialty drug issue as well. The Medicaid fee schedule would be for all drugs. So if the first proposed amendment language line was adopted, there would be no need to include the second proposed line.

Chairman Judy Lee asked Dr. Joyce what for comment on number 1.

Dr. Joyce responded that the only thing that would be bad is that we don't currently have the Medicaid fee schedule in statute, for obvious reasons such that we need to make changes as you need to. Although the good thing is that it eliminates all arguments. Medicaid would be stating this is your fee schedule, and this what you'll need to pay, and that is what they would end up doing. The only other bad thing that could come of it is if the federal government does require us to change our reimbursement methodology, then there could be some issues with that. It would change for everybody, but it could be complicated. The feds are talking about using an actual acquisition cost methodology, that some private sector PBM's are not capable of doing. This is in draft from the feds, and it is not necessarily something that is going to happen. It would actually be one of the first time the feds would ever say you have to pay in this fashion.

Chairman Judy Lee stated she can't imagine being so specific that we would put the actual fee schedule in statute.

Senator Howard Anderson, Jr. doesn't think we need the actual fee schedule in statute, but just the words Medicaid fee schedule. This then allows the Department of Human Services to deal with it in rule or policy.

Dr. Joyce confirmed. There could be complications if the federal rule goes through.

Chairman Judy Lee asked if the feds change the rules, don't you just change the fee schedule.

Dr. Joyce stated the new process would be the actual acquisition cost. What that means is essentially all drug maximum allowable cost list, to where the feds do a weekly survey of drug pricing, and they come out every week for the acquisition costs for medications. Then the dispensing fee is based on the cost of the dispensing survey. This fee ends up being $10.50 per prescription in some states, and in some states it is $12.00. Sometimes they have different ones for different volumes of pharmacies, so it can be complex. If we end up with the proposed amendment in statute, and we end up making that change, we would keep it as simple as possible.

Chairman Judy Lee voiced her concerns if we are too specific in statute. It would negate the whole thing accomplished in prior sessions; for example, where the rural pharmacies were reimbursed at a higher level because the volume wasn't there. If we did that, don't we eliminate the ability to have the differential which was done with Sanford Health?

Dr. Joyce responded yes, the Sanford negotiations discussions that they had with the different pharmacies - it would eliminate that. If we would had this in the current contract to start with, we wouldn't have had those discussions.

Dr. Joyce voiced that they have learned a lot of lessons, and have tried to address some of the most important ones in the amendments put in on the House side.

Chairman Judy Lee asked if Dr. Joyce likes Senator Howard Anderson, Jr.'s suggested language or if he likes the original language better.

Dr. Joyce responded that he prefers to have one rate, which is what Senator Howard Anderson, Jr. language does.

Chairman Judy Lee also asked Mr. Tupa and Mr. Schwab to comment on preference. **Mr. Schwab** indicated his preference would be the Senator Howard Anderson, Jr. language. **Mr. Tupa** did not have a position either way. Mr. Tupa indicated he does not represent any of the PBM's and was here for another bill.

Dr. Joyce stated to have the one rate would be equivalent to what Workforce Safety does. They hire a PBM and tell them the rate.

V. Chairman Oley Larsen suggested that the language be shared with Mr. Rod St. Aubyn for his input. The committee agreed.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/17/2015
24939

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the Medicaid expansion program

Minutes: No attachments

The Senate Human Services Committee met on March 17, 2015 to discuss HB 1041 in committee work.

Chairman Judy Lee reviewed the testimony and discussion for HB 1041. Discussions included:

- No issues with the amendments proposed by Jennifer Clark, Legislative Management
- Page 1, lines 19 to 21, regarding minimum and maximum range, and replacing this with the Medicaid rate. The committee concurred to this. Chairman Judy Lee asked **Julie Leer** from the Department of Human Services to help the intern, Femi, with this language.

Senator Warner asked the committee, is the Medicaid rate based on the wholesale rate, minus 10%, plus $5.00.

Senator Howard Anderson, Jr. responded that it is a little more complicated than that. It is not a $5.00 fee but instead $4+ fee, and right now Medicaid sets that as the average wholesale price (AWP) minus $10.00 plus their fee. Medicaid and the feds are always working on how they can set the acquisition costs. The feds are moving towards an actual acquisition cost. The fee would be set in each state based on surveys of pharmacies and their cost of dispensing. The idea the feds would like is to fix the cost of what everybody really pays. Currently, that is a fungible number. Some people get a discount from the average wholesale price, some people get rebates from manufacturers when they purchase things. The difficulty is getting a reporting system that accurately reflects what they actually pay because there are so many issues. Once they arrive at that, the fee would actually be re-determined based on dispensing surveys in the state. So it would change from what it is now, but nonetheless, there is a process in place to fix it today.

Senator Warner indicated that he no longer has any pharmacies in his district, which is 5,200 square miles. But they do have tele-pharmacy. He assumes big-chain pharmacies would have volume discounts, which isn't an issue in North Dakota. Do the independent pharmacies have buying alliances or coops that they can generate those kind of volume discounts?

Senator Howard Anderson, Jr. stated there are buying coops that independent pharmacies are members of. There is one alliance where there are about 4,000 pharmacies in that. Most wholesalers actually have a buying group in buying generic drugs that their pharmacies participate in, and that is where the rebates come on the back side. The feds are trying to include all of those in the actual acquisition costs. You take the rebates off the AWP and the rebates again on the back side and get to a price that is actually paid by people. Large chains have their own buying group.

Chairman Judy Lee found the language that had been suggested, "provide and implement the Medicaid fee schedule for reimbursement of all medications and dispensing fees." Chairman Judy Lee asked if **Julie Leer**, Department of Human Services, could review this language. The committee concurred they would like the intent of this language included for a single rate.

Chairman Judy Lee reviewed the changes proposed by Jennifer Clark, Legislative Management, as discussed in prior testimony and committee work.

Senator Warner asked a question relative to pharmacies giving vaccinations, can they buy vaccines at the Medicaid rate also.

Senator Howard Anderson, Jr. answered when talking about the Medicaid rate, there is really no Medicaid rate for purchasing things. They would buy those at the same rate they would buy their other products. The state does have a discounted rate for some of the vaccines that are purchased and given out from the state. But pharmacies don't buy them at that rate. If they are using vaccines for eligible patients, the pharmacies can get them from the state cache and then they are used for those eligible patients in those few areas. Some of the pharmacies do provide that service. Most of the vaccines the pharmacy administers would be bought at their regular contracts with their regular suppliers.

Senator Warner asked if there are vaccines fungible within their stockpiles so you do not have to maintain separate vaccines.

Chairman Judy Lee answered this is very complicated and frustrating. This is a Health Department issue. There are four stashes of vaccines that must be separated in a refrigerator and you can't take from one and move to another, so you may have to go across the county to get from the proper stash for whichever group of children you are vaccinating. There is nothing simple about vaccine processing.

Senator Howard Anderson, Jr. stated there are certain instances when the federal law states that manufacturers "will give" a certain discount, such as a 35% discount. Some of those vaccines are purchased by the Health Department for eligible patients. But the

manufacturer doesn't want anybody using those discounted purchases for non-eligible patients. On the vaccine, you actually record the manufacturer and the lot number that you administered to the patient so it is tracked.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/17/2015
25004

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the Medicaid expansion program

Minutes:

Attach #1: Draft Bill with Proposed Amendments

The Senate Human Services Committee met on March 17, 2015, 2:29 p.m., to discuss HB 1041 in committee work.

The draft HB 1041 with the proposed amendments was distributed to the committee members (attach #1).

Mr. Rod St. Aubyn, representing the PCMA, provided clarification. The information they heard on the payback, Pat Ward is the one who handles Express Scripts, and he was waiting to get some information. His initial information was that the paybacks that Pharma is pushing name brand drugs. They would give a coupon for copay, so there would be a higher cost because of the name brand when there was a generic in that particular case. In talking with Dr. Brenden Joyce, and his understanding is that he has seen it on generics as well. Mr. Aubyn asked if the committee could wait until tomorrow, we can respond honestly what we find out on this. The people we talked to didn't know anything about it, but Dr. Joyce indicated several Pharmacy Benefit Managers (PBM) are doing this. His understanding is that Parma is pushing the name brand versus the generic, the clawback was to recoup some of the cost of the more expensive drug.

Chairman Judy Lee stated the information is so muffled.

Mr. St. Aubyn concurred. We don't want to pay more money. He still thinks HB 1041 is not necessary. Dr. Joyce feels he could do it cheaper through the Department of Human Services versus going through the PBM. Through Medicaid expansion, it was required to go through private.

Mr. St. Aubyn if it is a situation with payback, and it is occurring with generic, can't imagine that there would be a coupon. **Chairman Judy Lee** responded the brand name companies have bought the generic companies.

Senator Howard Anderson, Jr. what we are seeing in today's market is generics are being bought out by brand name companies. There are probably more rebates on generics today; prices have gone up significantly on generics.

Chairman Judy Lee set this one aside.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/17/2015
25012

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the Medicaid expansion program

Minutes: No attachments

The Senate Human Services Committee met on March 17, 2015 to discuss HB 1041 in committee work, third time.

Dr. Brenden Joyce, Department of Human Services, stated the Medicaid fee schedule could replace the minimum/maximum language. This is something that could be shared with whatever pharmacy benefit management (PBM) is going to operating the program and we could give it to them weekly and keep them updated. We can do this if the legislature asks us.

2015 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1041
3/24/2015
25330

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Donald Mueller

Explanation or reason for introduction of bill/resolution:

A bill relating to pharmacy benefit management services for the medicaid expansion program

Minutes:

Attach #1: Proposed Amendment

The Senate Human Services Committee met on March 24, 2015 for HB 1041 committee work.

Maggie Anderson (DHS) discussed the minimum or maximum, or the Medicaid rate. If it is changed to Medicaid, there will be a fiscal note. So we would prefer to do the minimum.

Chairman Judy Lee handed out the proposed amendment from Rod St. Aubyn. (attach #1) Chairman Judy Lee explained the language in the proposed amendment. Rod's proposed language would be line 17, and the minimum would be line 20.

Maggie Anderson (DHS) doesn't see the language would have a negative impact.

Senator Howard Anderson, Jr. it would mean that you wouldn't get any publication until January 1, 2016.

Maggie Anderson (DHS) confirmed, that some of the data we wouldn't have until then.

Chairman Judy Lee indicated the this amendment would plug into the amendment previously provided. We've eliminated the "and maximum." We talked about the reimbursement, "must" on lines 19, 20, 21.

Maggie Anderson (DHS) asked for clarification, page 1 of the engrossed bill, we use the word minimum twice. It appears that both minimums have been struck. We do not want to do that. The minimum needs to stay before the maximum.

Chairman Judy Lee and the committee confirmed. They read through the bill with the proposed changes.

Maggie Anderson (DHS) asked the way it came from the House, that mail order cannot be the sole order of service. So if you live in an area where the health plan has not been able to secure, does it have a double meaning to it?

Senator Howard Anderson, Jr. stated that it can't just be mail order. That was the intent. **V. Chairman Oley Larsen** stated that language came from Jennifer Clark, legislative management.

Senator Warner requested clarification on subsection d, starting on line 7, "to ensure that the pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification." Wasn't there some concern that we were imposing an externality on pharmacies that we had no jurisdiction?

Senator Howard Anderson, Jr. responded that Brenden Joyce stated that we have the right that we have now set what we pay for all over the country, so that shouldn't be a problem.

Maggie Anderson (DHS) this is a requirement to the health plan, and not to the pharmacy. It is no additional work to the pharmacy, but it could be additional work to the health plan.

Senator Dever commented the voting laws say that residency is where it is until you establish it somewhere else. Does that apply here?

Maggie Anderson (DHS) answered within Medicaid, if you are individual over age of 21 and you arrive in North Dakota, you can apply for Medicaid in North Dakota. That individual may move somewhere else and not notify the state about the change in residence - we don't want to pay while they are somewhere else.

Senator Dever asked for clarification, so they don't have to be a resident for 30 days.

Maggie Anderson (DHS) answered no, not for Medicaid purposes.

V. Chairman Oley Larsen commented that goes with the federal government and a health event, where you can change your health plan. If you change your geographical area, because they've changed their event, they can change residence.

Maggie Anderson (DHS) stated that someone moving like that, there are various components of your eligibility, one of them being income, and that would likely change with a move like that, and so it is important that you are applying in the state where you are currently a resident and you continue to meet the eligibility criteria, including financial. Because Medicaid expansion is a premium, where we pay for the month, that person would have coverage through the end of the month in which we become aware of a residency change. If they continue to be Medicaid eligible in the other state, then they can apply there. This is not new due to Medicaid expansion, but something that the Department of Human Services has been attentive to because of traditional Medicaid.

Senator Howard Anderson, Jr. moved to ADOPT AMENDMENT, including the line from Mr. Rod St. Aubyn. The motion was seconded by **Senator Axness**. No discussion.

Roll Call Vote to Amend
6 Yes, 0 No, 0 Absent. Motion passes.

Senator Howard Anderson, Jr. moved the Senate Human Services Committee DO PASS HB 1041 AS AMENDED. The motion was seconded by **Senator Axness**. No discussion.

Roll Call Vote
6 Yes, 0 No, 0 Absent. Motion passes.

Senator Howard Anderson, Jr. will carry HB 1041 to the floor.

Adopted by the Human Services Committee

March 24, 2015

TV
3/24/15

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1041

Page 1, line 2, after "program" insert "; and to provide for application"

Page 1, line 20, after "identifies" insert "the"

Page 1, line 20, replace "and maximum amounts" with "amount"

Page 1, line 20, after "pharmacy" insert "providers for each medication. The reimbursement"

Page 2, line 6, remove "only"

Page 2, line 6, after "order" insert "to be the sole method of service"

Page 2, line 11, replace "its" with "the private carrier's"

Page 2, line 11, replace "that" with "which"

Page 2, after line 16, insert:

"**SECTION 2. APPLICATION.** This Act applies to a contract entered or renewed on or after the effective date of this Act."

Renumber accordingly

Date: 03/24 2015
Roll Call Vote #: 1

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1041

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15. 0303. 02001 Title 03000

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen Anderson Seconded By Sen Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 03/24 2015
Roll Call Vote #: 9

2015 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1041

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 15.0303.02001 Title 03000

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Anderson Seconded By Sen. Axness

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	✓		Senator Tyler Axness	✓	
Senator Oley Larsen (V-Chair)	✓		Senator John M. Warner	✓	
Senator Howard C. Anderson, Jr.	✓				
Senator Dick Dever	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1041, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1041 was placed on the Sixth order on the calendar.

Page 1, line 2, after "program" insert "; and to provide for application"

Page 1, line 20, after "identifies" insert "the"

Page 1, line 20, replace "and maximum amounts" with "amount"

Page 1, line 20, after "pharmacy" insert "providers for each medication. The reimbursement"

Page 2, line 6, remove "only"

Page 2, line 6, after "order" insert "to be the sole method of service"

Page 2, line 11, replace "its" with "the private carrier's"

Page 2, line 11, replace "that" with "which"

Page 2, after line 16, insert:

"**SECTION 2. APPLICATION.** This Act applies to a contract entered or renewed on or after the effective date of this Act."

Renumber accordingly

2015 TESTIMONY

HB 1041

#1

Testimony
House Bill 1041 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 12, 2015

Chairman Weisz, and members of the House Human Services Committee, I am Brendan Joyce, PharmD, Administrator of Pharmacy Services for the Medical Services Division of the Department of Human Services (Department). I am here today to provide information regarding House Bill 1041.

At the conclusion of the 2013 legislative session, the Department began work on implementation of the Medicaid Expansion. This involved significant time for Department staff and staff from the Centers for Medicare and Medicaid Services (CMS). It is important to note that CMS staff were organized into very efficient "topic specific" teams and were directed to ensure that states electing to expand, would be able to successfully launch their Medicaid Expansion programs by January 1, 2014. With all of this effort on both the state and federal ends, as well as the efforts of the health plan vendor, the contract was approved by CMS and signed by the Department and the Sanford Health Plan on December 31, 2013 – one day before the launch of North Dakota Medicaid Expansion coverage.

According to procurement rules, Subsection 3 of Section 1 of HB 1041 is a significant scope change such that the Department would have to re-procure the health plan (re-bid the contract). CMS resources have returned to their pre-Medicaid Expansion work, which will impact the amount of time needed to finish a re-procurement and secure a new contract. Given this, if HB 1041 passes, the Department expects the

effective date for a new contract as a result of a re-procurement to be no sooner than January 1, 2017. The Department is requesting an effective date of January 1, 2017 be added HB 1041 to coincide with the changes proposed in this bill.

With regards to Subsection 3 of Section 1 of HB 1041, if the pharmacy benefits are provided by an entity unrelated to the entity that provides medical benefit, DHS will ensure the facilitation of data sharing in both directions to allow the vendors to have complete patient information so as to provide the best care coordination possible for their recipients. For instance, the pharmacy benefit manager needs to know a patient's diagnosis to ensure they provide coverage for the most appropriate medication for that patient, and the medical benefit provider needs to know the medication a patient is taking to ensure proper physician visits are taking place to monitor that medication.

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated (per member per month) rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan which contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program

would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model.

Subsection 3.b.4 of HB 1041 requires an annual audit of the pharmacy benefit manager if the pharmacy benefits are not managed by the Department. As reflected in the fiscal note for HB 1041, the estimated costs for that service are $100,000 per annual audit. If this section remains in the bill, the Department requests an appropriation be added to cover the expected costs of the audit.

This concludes my testimony. I would be happy to answer any questions the committee may have. Thank you.

#9

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

House Human Service Committee

HB 1041 – 1/12/15

9:30 – Fort Union Room

Chairman and members of the Committee, for the record my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association (NDPhA). We are here today in support of HB 1041, which comes from the Interim Committee on Health Reform.

The North Dakota Pharmacists Association has educated and advocated for increased transparency of pharmacy benefit manager (PBM) practices and the model it which they operate under. This bill would build on the history of the North Dakota Legislature passing and implementing other transparency requirements of PBMs and how they operate for State plans as well as commercial plans.

We would like to offer one short amendment to HB 1041. On page 2, we would like to replace letter (b) with the following:

b. If the pharmacy benefit management component is not provided through the department, any contract between the department for the pharmacy benefit management component must provide for:

Thank you for your time this morning. I would be happy to try and answer any questions.

Respectfully,

Mike

Mike Schwab

EVP NDPhA

#3

January 16, 2011

HOUSE HUMAN SERVICES COMMITTEE
HB 1041

CHAIRMAN WEISZ AND MEMBERS OF THE COMMITTEE:

My name is Jack McDonald. I am appearing today on behalf of Prime Therapeutics, a pharmacy benefit manager who works primarily for Blue Cross-Blue Shield.

Prime is taking a neutral position on this bill, but does believe that if it is enacted there is a need for a confidentiality clause to protect the proprietary information that would be submitted by the pharmacy benefit companies.

Therefore, we respectfully request that you amend the bill as I've indicated below.

If you have any questions, I will be happy to try to answer them. THANK YOU FOR YOUR TIME AND CONSIDERATION.

PROPOSED AMENDMENTS TO HOUSE BILL 1041 as introduced

Page 2, after line 11, insert

"c. Any information provided to the department of human services or any audit firm by a pharmacy benefit manager under this section shall be confidential pursuant to section 44-04-17.1 of the North Dakota Century Code."

Renumber accordingly

#4

STATEMENT

PhRMA
RESEARCH PROGRESS HOPE

January 12, 2015

North Dakota House Bill 1041

January 10, 2015

Position: The Pharmaceutical Research and Manufacturers of American (PhRMA) appreciates the intent of HB 1041 to promote transparency and accountability. However, PhRMA has concerns with the legislation as currently drafted because it would require PBMs to disclose proprietary contracts and financial agreements for those servicing the Medicaid Managed Care expansion population without including a protection for confidential information. As a result, it could jeopardize confidential trade secret agreements and compromise competition.

HB 1041 would require the disclosure of propriety agreements between a PBM servicing the Medicaid expansion population and prescription drug manufacturers. Such contracts are considered trade secrets and require confidentiality protection. As written, this bill could unintentionally compromise business agreements between drug manufacturers and PBMs.

A trade secret is "any information that can be used in the operation of a business or other enterprise and that is sufficiently valuable and secret to afford an actual or potential economic advantage over others." *Restatement (Third) of Unfair Competition § 39 (1995).* The definition includes compilations of data, pricing, marketing techniques, and the identity of customers. Business and negotiating strategies vary by manufacturer, and those strategies are the product of focused research and ongoing relationships with healthcare providers. Manufacturers engage in strategic negotiations with clients to ensure that the most appropriate contract is approved for each individual client's needs. Disclosure of the agreed upon terms for one client might compromise competition in drug negotiations with other clients. Such financial strategies are closely guarded by each manufacturer and are not commonly known.

The risk of disclosing confidential trade secrets can be eliminated by stipulating that rebate information is to be disclosed "in aggregate." The Affordable Care Act requires similar disclosure in aggregate in Medicare Part D and the Marketplaces (Exchanges). This clarification will provide the State with the information it needs to carry out its Medicaid obligations while protecting the confidentiality of the financial information in a manner that will not undermine business in the state.

PhRMA urges North Dakota legislators to amend HB 1041 to ensure the protection of confidential trade secrets.

/

Phrma amendment

PROPOSED AMENDMENT TO HOUSE BILL NO. 1041

Page 2, line 7, after "rebates" insert "in aggregate"

And renumber accordingly

2-17-15

#1

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1041

Page 1, remove lines 19 through 24

Page 2, line 1, remove "b. If the pharmacy benefit management component is not provided through the"

Page 2, line 2, replace "department, the" with "The"

Page 2, line 2, remove "pharmacy benefit"

Page 2, line 3, replace "manager" with "private carrier"

Page 2, line 3, remove "provide for"

Page 2, remove lines 4 through 6

Page 2, line 7, replace "(3) Full" with:

"a. Provide a reimbursement methodology for all medications and dispensing fees which identifies minimum and maximum amounts paid to pharmacy providers for each medication. In addition, the reimbursement methodology, at a minimum, must:

(1) Be available on the department's website.

(2) Encompass all types of pharmacy providers regardless of whether the pharmacy benefits are being paid through the private carrier or contractor or subcontractor of the private carrier under this section.

b. Provide full"

Page 2, line 7, replace "; and" with an underscored period

Page 2, replace lines 8 through 11 with:

"c. Allow an individual to obtain medication from a pharmacy that provides mail order service; however, the contract may not require only mail-order.

d. Ensure that pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification.

e. Ensure the payments to pharmacy providers do not include a required payback amount to the private carrier or one of its contractors or subcontractors that is not representative of the amounts allowed under the reimbursement methodology provided in subdivision a."

Renumber accordingly

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

Attachment 1
HB 1041
03/16/15
24850

Senate Human Service Committee

HB 1041 – 3/16/15

9:00 – Red River Room

Madam Chair and members of the Committee, for the record my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association (NDPhA). We are here today in support of HB 1041, which comes from the Interim Health Reform Committee.

The North Dakota Pharmacists Association has educated and advocated for increased transparency of pharmacy benefit manager (PBM) practices and the model it which they operate under. This bill would build on the history of the North Dakota Legislature passing and implementing other transparency requirements of PBMs and how they operate for State plans as well as commercial plans.

HB 1041 was amended in the House based off of suggested language provided by the Department of Human Services. We support the amendments that were adopted and support the engrossed version of the bill in front of you.

Thank you for your time this morning. I would be happy to try and answer any questions.

Respectfully,

Mike Schwab

Mike Schwab
EVP NDPhA

HB1041
03/16/2015
Attach #2
24850

March 16, 2015

SENATE HUMAN SERVICES COMMITTEE
HB 1041

CHAIRMAN LEE AND MEMBERS OF THE COMMITTEE:

My name is Jack McDonald. I am appearing today on behalf of Prime Therapeutics, a pharmacy benefit manager who works primarily for Blue Cross-Blue Shield.

Prime is opposed to this bill. It is unnecessary since the Department of Human Services can already take any actions needed to implement contracts covering Medicaid expansion.

HB 1041, as extensively amended in the House, also forces pharmacy benefit managers (PBMs) to reveal confidential and proprietary information.

Our first choice is to give this bill a DO NOT PASS. However, if this is not your first choice, then we respectfully request that you amend the bill as I've indicated below. I've also attached a marked-up copy of the bill that shows the effect of our proposed amendments.

If you have any questions, I will be happy to try to answer them. THANK YOU FOR YOUR TIME AND CONSIDERATION.

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1041

On page 1, delete lines 19-22
On page 2, delete lines 1-3
On page 2, line 4, change "b." to "a."
On page 2, line 5, change "c." to "b."
On Page 2, delete lines 7-13
On page 2, line 14, change "f." to "c."
Renumber accordingly.

Sixty-fourth
Legislative Assembly
of North Dakota

ENGROSSED HOUSE BILL NO. 1041

Introduced by

Legislative Management

(Health Care Reform Review Committee)

A BILL for an Act to amend and reenact section 50-24.1-37 of the North Dakota Century Code, relating to pharmacy benefit management services for the medicaid expansion program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. (Effective January 1, 2014, through July 31, 2017) Medicaid expansion.

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty level, based on modified adjusted gross income.
2. The department of human services shall inform new enrollees in the medical assistance program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.
3. The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange. The contract between the department and the private carrier must:

~~a. Provide a reimbursement methodology for all medications and dispensing fees which identifies minimum and maximum amounts paid to pharmacy methodology, at a minimum, must:~~

~~(1) Be available on the department's website; and~~

~~(2) Encompass all types of pharmacy providers regardless of whether the pharmacy benefits are being paid through the private carrier or contractor or subcontractor of the private carrier under this section.~~

~~b.~~ a. Provide full transparency of all costs and all rebates in aggregate.

~~c.~~b. Allow an individual to obtain medication from a pharmacy that provides mail order service; however, the contract may not require only mail order.

~~d. Ensure that pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification.~~

~~e. Ensure the payments to pharmacy providers do not include a required payback amount to the private carrier or one of its contractors or subcontractors that is not representative of the amounts allowed under the reimbursement methodology provided in subdivision a.~~

~~f.~~ c. Any information provided to the department of human services or any audit firm by a pharmacy benefit manager under this section is confidential under section 44-04-17.1.

Attach#3
HB1041
03/16/15
J# 24850

Testimony on HB 1041
Senate Human Services Committee
Monday, March 16, 2015

Madam Chair and committee members, for the record I am Rod St. Aubyn representing the Pharmacy Management Care Association (PCMA), which is a trade association for the pharmacy benefit managers (PBM's).

As has been previously explained, HB 1041 was introduced by the Health Care Reform Review Committee to address problems that occurred with the original contract between the Medicaid Division and the contractor (Sanford Health Plan) that was awarded the Medicaid Expansion contract for ND. The problems that occurred have since been resolved and the bill is really unnecessary. In fact, there is absolutely no reason why the Medicaid department could not establish some of these requirements in their bid proposal. However, if these provisions were required, it would be doubtful that anyone would offer a bid.

Unfortunately, the bill was amended at the last minute during the committee work in the House and there was virtually no time to address the amendments that were adopted in an open hearing.

As a result, we vehemently oppose the bill as currently written. The amendments create an unmanageable situation and will most likely raise costs for Medicaid. The amendments do not make sense. On page 1, beginning on line 19 it requires that the reimbursement methodology must be provided on the department's website and that it must identify minimum and maximum amounts paid to pharmacies. Typically in ND, PBM's, working for their insurer, must reimburse higher amounts for rural pharmacies because of their limited prescription volume and to ensure an adequate network that is required by the State and also the Federal government. If the PBM's would have to disclose these minimums and maximums, the minimums would quickly become the maximums and raise the cost of prescription services for ND Medicaid Expansion.

Subdivision d. beginning on page 2, line 7, is probably illegal as we most likely cannot control other state's pharmacies.

We have no problem with transparency with the Medicaid division but because of proprietary information we would object to requiring that this proprietary and confidential information be released to the public.

We would support the amendments offered by Mr. McDonald. Otherwise, we would recommend a Do Not Pass recommendation for HB 1041. As I mentioned before, this is best left for the specifications when the Department bids these services.

Thank you for the opportunity to testify. I would be willing to try to answer any questions.

Attach #4
HB 1041
03/16/2015
J# 24850

THE HARMS GROUP

Senate Human Service Committee

March 16, 2015

Chairman Lee and Members of the Human Service Committee,

My name is Robert Harms. I am the lobbyist for CVS Health who is opposed to Engrossed HB 1041. CVS Health operates a PBM---a pharmacy benefits management company that provides service in North Dakota.

We are opposed to Engrossed HB 1041 for several reasons.

1. First the bill is unnecessary and invades the contract domain between the Medicaid program and private providers who contract with the Department of Human Services. There is no reason that the terms of the contract require mandates as described in the bill----and more importantly if retained are likely to discourage others from bidding on the contract in the future. The state wants more competition for the Medicaid contract---not less.

2. The bill sets up a "minimum and maximum" payment threshold that essentially will default to the high-end---ultimately increasing costs to the provider (and the tax payers). Although CVS does not provide services to the Medicaid program---we may wish to compete for it one day. But more importantly we think Engrossed HB 1041 sets bad public policy that may find its way into our book of business in the future, so we are opposed to the bill for that reason as well.

3. The bill contains provisions that are vague and are unenforceable and require the publication of what essentially will be proprietary information (such as the minimum/maximum amounts above). For example:

P. 2, line 4 says the contract must provide for "full transparency" of all costs and rebates

P. 2, line 7 attempts to mandate prior authorizations in neighboring jurisdictions.

These provisions are unenforceable, and will be difficult to comply with by the provider.

We agree with amendments submitted earlier by Mr. McDonald, and if those amendments are adopted we would be able to support the bill, but still believe it is unnecessary legislation.

Thank you.

Robert W. Harms

Robert W. Harms

Attach #1
HB 1041
03/16/2015

Possible amendment for HB 1041

(1) Provide and implement the Medicaid fee schedule for reimbursement of all medications and dispensing fees.

J# 24911

This was actually brought up in discussions on the House and of course Brendan stated the Department would implement whatever the legislature directed them to do. Rep. Porter and Rep. Weisz asked why don't we just reimburse pharmacies off the current Medicaid fee schedule since this is just an expansion of Medicaid. The bill sat in their committee for 5 weeks and during committee work, it never came up again nor were we asked to comment. Either way, Page 1 line 19 helps to address the issue but still leaves the PBM some wiggle room to squeeze some providers and potentially still pay themselves more than what they might pay a pharmacy for the same drug.

Possible amendment to offer for HB 1041

(1) For specialty drugs, the contract must contain drug-by-drug guarantees that assure that the State is obtaining competitive pricing.

This amendment would guarantee the State is obtaining competitive prices on ALL SPECIALTY DRUGS not just the list the PBM provides. Typically a PBM will give a guarantee on 200 specialty drugs for example but there are already about 800+ and I will leave it up to you to determine what happens with the other 600+ specialty drugs (basically you pay whatever the PBM charges per se because there is no guarantee especially if it is filled at the PBM owned specialty mail order facilities).

Attach #1
HB1041
03/19/2015
J#25004

ENGROSSED HB 1041 DRAFT AMENDMENT

SECTION1. AMENDMENT. Section 50-24.1-37 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-37. (Effective January 1, 2014, through July 31, 2017) Medicaid expansion.

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148],as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L.111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty level, based on modified adjusted gross income.

2. The department of human services shall inform new enrollees in the medical assistance program that benefits may be reduced or eliminated if federal participation decreases or is eliminated.

3. The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange. The contract between the department and the private carrier must:

a. Provide ~~a~~ and implement the medicaid fee schedule for reimbursement ~~methodology for~~of all medications and dispensing fees which ~~identifies minimum and maximum amounts paid to pharmacy methodology~~, at a minimum, must:

(1) Be available on the department's website; and

(2) Encompass all types of pharmacy providers regardless of whether the pharmacy benefits are being paid through the private carrier or contractor or subcontractor of the private carrier under this section.

b. Provide full transparency of all costs and all rebates in aggregate.

c. Allow an individual to obtain medication from a pharmacy that provides mail order service; however, the contract may not require ~~only~~ that mail order be the sole method of service.

d. Ensure that pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification.

e. Ensure the payments to pharmacy providers do not include a required payback amount to the private carrier or one of ~~its~~ the private carrier's contractors or subcontractors ~~that~~ which is not representative of the amounts allowed under the reimbursement methodology provided in subdivision a.

f. Any information provided to the department of human services or any audit firm by a pharmacy benefit manager under this section is confidential under section 44-04-17.1.

Attach #1
HB 1041
03/24/15
J# 25330

Suggested amendment to Engrossed HB 1041 Draft Amendment-

In subsection 3, replace the second sentence with "After August 1, 2015, any new or renewed contract between the department and the private carrier must:"