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Fifty-ninth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1332

Introduced by

Representatives N. Johnson, Devlin, Keiser, Price

Senators Fischer, J. Lee

A BILL for an Act to create and enact a new section to chapter 26.1-27 and chapter 26.1-27.1 of the North Dakota Century Code, relating to regulation of pharmacy benefits management.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-27 of the North Dakota Century Code is created and enacted as follows:

Pharmacy benefits manager. A pharmacy benefits manager, as defined under section 26.1-27.1-01, is an administrator for purposes of this chapter.

SECTION 2. Chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

26.1-27.1-01. Definitions. In this chapter, unless the context otherwise requires:

1. "Covered entity" means a nonprofit hospital or a medical service corporation; a health insurer; a health benefit plan; a health maintenance organization; a health program administered by the state in the capacity of provider of health coverage; or an employer, a labor union, or other entity organized in the state which provides health coverage to covered individuals who are employed or reside in the state. The term does not include a self-funded plan that is exempt from state regulation pursuant to the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.]; a plan issued for coverage for federal employees; or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care, or other limited-benefit health insurance policy or contract.
2. "Covered individual" means a member, a participant, an enrollee, a contractholder, a policyholder, or a beneficiary of a covered entity who is provided health coverage

by the covered entity. The term includes a dependent or other individual provided health coverage through a policy, contract, or plan for a covered individual.

3. "De-identified information" means information from which the name, address, telephone number, and other variables have been removed in accordance with requirements of title 45, Code of Federal Regulations, part 164, section 512, subsections (a) or (b).

4. "Generic drug" means a drug that is chemically equivalent to a brand name drug for which the patent has expired.

5. "Labeler" means a person that has been assigned a labeler code by the federal food and drug administration under title 21, Code of Federal Regulations, part 207, section 20, and that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

6. "Pharmacy benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation within this state to covered individuals; the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals; or the providing of any of the following services with regard to the administration of the following pharmacy benefits:
   a. Mail service pharmacy;
   b. Claims processing, retail network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;
   c. Clinical formulary development and management services; or
   d. Rebate contracting and administration.

7. "Pharmacy benefits manager" means a person that performs pharmacy benefits management. The term includes a person acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity and includes mail service pharmacy. The term does not include a public self-funded pool or a private single-employer self-funded plan that provides benefits or services directly to its beneficiaries. The term does not include a health carrier licensed under title 26.1 if the health carrier is providing pharmacy benefits management to its insureds and does not include a

public self-funded pool or a private single-employer self-funded plan that provides pharmacy benefits management directly to its beneficiaries.

8. "Rebate" includes the nature, type, and amount of all other revenue received by the pharmacy benefits manager from each pharmaceutical manufacturer or labeler for any other product or service provided, including any formulary management and drug-switch program, educational support, claims processing, and pharmacy network fees that are changed from retail pharmacies and data sales fees, with respect to programs that the covered entity offers or provides to the covered entity's enrollees.

9. "Utilization information" means de-identified information regarding the quantity of drug prescriptions dispensed to members of a health plan during a specified time period.

26.1-27.1-02. Licensing. A person may not perform or act as a pharmacy benefits manager in this state unless that person holds a certificate of registration as an administrator under chapter 26.1-27.

26.1-27.1-03. Disclosure requirements.

1. A pharmacy benefits manager shall disclose to the commissioner any ownership interest of any kind with:
   a. Any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the pharmacy benefits manager provides services.
   b. Any parent company, subsidiary, or other organization that is related to the provision of pharmacy services, the provision of other prescription drug or device services, or a pharmaceutical manufacturer.
2. A pharmacy benefits manager shall notify the commissioner in writing within five business days of any material change in the pharmacy benefits manager's ownership.

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager may not request a substitution of one prescription drug for another unless:

a. The pharmacy benefits manager requests that a lower-priced generic or therapeutically equivalent drug be substituted for a higher-priced prescribed drug; or

b. The substitution is for medical reasons that benefit the covered individual and the pharmacy benefits manager obtains the approval of the prescribing health professional.

2. A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one contract in order to participate in another contract. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in a particular network solely because the pharmacist or pharmacy declined to participate in another plan or network managed by the pharmacy benefits manager.

3. When contracting with pharmacies, a pharmacy benefits manager may not discriminate on the basis of copayments or days of supply. A contract must apply the same coinsurance, copayment, and deductible to covered drug prescriptions filled by any pharmacist or pharmacy who participates in the network.

4. This section does not permit the substitution of an equivalent drug product contrary to section 19-02.1-02.

26.1-27.1-05. Contents of pharmacy benefits management agreement - Requirements.

1. A pharmacy benefits manager shall offer to a covered entity options for the covered entity to contract for services that must include:

a. A transaction fee without a sharing of rebates and other retrospective utilization discounts;

b. A combination of a transaction fee and a sharing of rebates and other retrospective utilization discounts; or

c. A transaction fee based on the covered entity receiving all the benefits of rebates and other retrospective utilization discounts.

2. The agreement between the pharmacy benefits manager and the covered entity must include a provision allowing the covered entity to audit the pharmacy benefits manager's books, accounts, and records, including de-identified utilization

information, as necessary to confirm that the benefit of rebates and other retrospective utilization discounts are being shared as required by the contract.

26.1-27.1-06. Examination of insurer-covered entity.

1. During an examination of a company as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the company and a pharmacy benefits manager and any related record to determine if the rebates and other retrospective utilization discount benefits that the company received from the pharmacy benefits manager have been applied toward reducing the company's rates or have been distributed to covered individuals.
2. To facilitate the examination of the company, the company shall disclose annually to the commissioner the benefits of rebates and other retrospective utilization discounts received under any contract with a pharmacy benefits manager and shall describe the manner in which the rebates and other retrospective utilization discounts are applied toward reducing rates.
3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1.

26.1-27.1-07. Rulemaking authority. The commissioner shall adopt rules as necessary before implementation of this chapter.