TESTIMONY OF SCOTT MILLER

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding House Bill 1233, and I will offer my comments relating to each section.

Section 1

HB 1233 would require NDPERS to conduct an audit of every Pharmacy Benefit Manager (PBM) providing "contract services" for the uniform group insurance program we use over the next biennium. Each of the audits "must be conducted in accordance with chapter 19-03.6." Page 1, lines 8-9. NDCC chapter 19-03.6 applies to the audit of pharmacies by entities like PBMs, rather than audits of PBMs by other entities. As such, we would appreciate clarification of what provisions in NDCC chapter 19-03.6 are intended to be applicable to our audits of PBMs.

NDPERS does not presently have nor do we anticipate we will have a contractual relationship with a PBM next biennium. We presently contract with Sanford Health Plan (SHP), which contracts with OptumRx's PBM services for active employees, and we contract with Medco Containment Life Insurance Company (MCLIC), which contracts with Express Scripts, Inc. (ESI) for PBM services for Medicare-eligible retired employees. Since we do not contract with a PBM to provide us services, but instead contract with insurance companies, the language in this bill does not appear to apply to our current coverage situation.

If NDPERS did have contracts directly with PBMs, which is common in a self-insured arrangement, rather than our current fully-insured arrangements, it is clear that the requirements of this bill would apply to NDPERS. Since we do not have these contracts, Section 1, Section 2, and Section 3 may not apply to NDPERS next biennium. Since those sections would not apply, then the Section 4 reporting requirement would also not apply.

Section 2

Section 2 of the bill sets forth the scope of the audit and what information the PBM must supply. If NDPERS did have a contract with a PBM, these requirements would need to be added to that contract and would be a minimum requirement for us to have with a

PBM to sign such a contract. If a PBM would not sign a contract with such provisions, then NDPERS would not be able to contract with that PBM. If no PBM was willing to sign a contract with these provisions, then NDPERS would not be able to contract with a PBM for the biennium. Guidance should be provided in the bill to NDPERS if it is unable to contract with a PBM for the provisions in Section 2. Since we do not contract with the PBMs, but instead contract with insurance companies, it would appear these provisions would not apply. However, if they were to apply, then clarification should be added to the bill on how we should apply these provisions to an entity we do not contract with.

Secondly, the bill provides no alternatives for NDPERS if no party is willing to add these provisions. If NDPERS is not able to add this to its fully insured contract with SHP, which was bid this last fall, does NDPERS need to rebid? If so, since there is not time to do a full rebid before the beginning of the next biennium, should NDPERS extend the existing contract until a new bid can be completed with the new minimum requirements? If NDPERS is not able to contract for these services with these minimum requirements with a PBM, then is it the intent of the bill that NDPERS would not provide prescription drug services to our members? Or would NDPERS have the authority to sign a contract with a PBM that met most of the requirements? Further guidance in the bill on these situations would be beneficial.

Also, regarding our current Part D provider, the plan is currently a fully insured Employer Group Waiver Plan (EGWP) pursuant to federal provisions, and, as such, does not have financial guarantees, average annual guarantees, specialty drug minimum guaranteed discounts, or financial benefit guarantees as outlined in Sections 1 and 3(a). The fully insured plan also does not participate in passthrough pricing as included in Sections 1 and 3(c) and 3(d). Sections 2 and 4 (page 3, line 22) also include pass-through pricing language that is not part of the current benefit design. As a fully insured Part D plan, this is not part of the structure. Therefore, consideration should be given to exempting Part D or requiring us to change to another plan structure allowed under federal law. If we do need to change plan structure, we would request that this not be effective for Part D until January 2023.

Section 3

Since PERS does not contract directly with a PBM, direction should be added to this section on how disputes would be resolved with the fully insured carrier if this is intended to apply to such arrangements.

Section 4

It may be beneficial to acknowledge that if this bill does not apply to NDPERS if it is fully insured, then these reporting requirements do not apply as well. If this reporting is required of NDPERS, we would suggest moving the date from July 1 to October 1.

Fiscal Note

We asked Deloitte to estimate the cost of this bill if it was applicable, and they noted that the audit requirements in this bill are very broad, and do not fit a single "typical" audit type for PBMs. Deloitte noted the audit requirements in this bill touch on many different audit topics and audit types. As such, Deloitte provided us with the below table of the audits we might perform to comply with this bill and their understanding of the cost of those audits in the marketplace, in thousands.

PBM audit type	Approx. fee range	Sample factors impacting pricing:
Claims/eligibility audit	$100 - $200	• Statistically significant sample (Not all claims)
Performance guarantee audit	$50 - $200	• Vendor based reporting compared to contract • Claims file review vs contract to validate vendor numbers • Clarifications on scope needed
Clinical audit/ fraud waste and abuse	$100 - $250	• Number/complexity of clinical decisions audited • Clarifications on scope needed
Rebate audit	$75 - $150	• Number of sampled manufacturers/drugs for audit • Number of contracts needed to cover all lines of business • Range assumes 1 year of contracts audited
Validation of Benefits (VOB)	$50 - $75	• Sample claims to validate payment according to benefit designs (vs pricing in PBM contract)

To create the fiscal note, we took the lowest numbers in the respective ranges, added them together, and multiplied that sum by the three PBMs with which we may work over the next two years: OptumRx (through SHP), Express Scripts Inc. (ESI) (our current Medicare Part D PBM, the services for which we contract through an agreement with MCLIC), and the PBM from which we obtain our Medicare Part D services in 2022 pursuant to the Request for Proposals we will issue in 2021 (if that changes). Given that any new PBM would begin providing services on January 1, 2022, I question what benefit we would gain by auditing that PBM, or how we would perform that audit in time to provide a report to the Legislative Management by July 1, 2022. Further, that provider will have no finalized claims history to even review. Nonetheless, those are requirements of this bill.

Summary

In recognition of the above, NDPERS would suggest:

1. Clearly specify if it is the intent for NDPERS to audit a PBM that it does not have a contract with but who may do work for firms we do contract with for health insurance services.
2. Since the bill establishes minimum requirements that were not a part of the bid specification for 2021-23, consideration should be given to making it applicable for the 2023-25 contract period so it can become a part of the minimum requirement for that contract. If this is to be effective for 21-23, and since it was not a part of the scope of work in that bid, we will need to renegotiate the arrangement with the new specifications.
3. Provide direction in the bill on what NDPERS should do if it is unable to get a contract with these provisions for the active and retiree plans.
4. If NDPERS is unable to get these provisions added to our existing fully insured contracts, should NDPERS have to rebid the plan before the beginning of the next biennium? If so, then consideration should be given to allowing NDPERS to offer a no bid contract since there would be insufficient time do a full bid or extending the existing arrangement until a new bid can be completed. It should also be noted that if a new bid is done, rates could change and if they go up, NDPERS would need to cut benefits so they match the premium, or subsidize the premium from reserves. If the Legislature would like to provide guidance to the Board on this it could be added to this bill
5. Consider not including the Retiree Part D plan since it is an EGWP under federal law.
6. Make it clear in section 4 that such a report will be provided only if NDPERS is able to get access to the contracts between SHP and OptumRx and Medco and ESI.