2025 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1584

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1584
2/11/2025

A BILL for an Act to create and enact two new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to provide a penalty; and to declare an emergency.

2:32 p.m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Member Absent: Representative Christy

Discussion Topics:

- Employee Retirement Income Security Act of 1974 (ERISA) plans
- Exemption for self-funded plans
- Pharmacy Services Administration Organization (PSAO)
- Joint powers agreement

2:33 p.m. Representative Jim Kasper, District 46, Fargo, ND, introduced, testified and submitted testimony #37157.

2:43 p.m. Robert T. Smith, Partner, Katten Muchin Rosenman LLP, testified in favor and submitted testimony #37006.

3:09 p.m. Mike Schwab, Executive Vice President, ND Pharmacists Association, testified in favor and submitted testimony #37138.

3:18 p.m. Arik Spencer, President & CEO, Greater North Dakota Chamber (GNDA), testified in opposition and submitted testimony #37038.

3:21 p.m. Michael Power, Assistant Vice President, State Affairs, Pharmaceutical Care Management Association (PCMA), testified in opposition and submitted testimony #37129

3:31 p.m. Alex Kelsch, Lobbyist, America's Health Insurance Plans (AHIP), testified in opposition and submitted testimony #37134, #37205.

3:44 p.m. Marcus P. Caruso, Government Affairs Principal, Prime Therapeutics, testified in opposition and submitted testimony #37111.

3:48 p.m. Rick Clayburgh, President & CEO, ND Bankers Association, ND Banks Benefit Trust, testified as neutral.

3:50 p.m. Mark Hardy, Executive Director, ND Board of Pharmacy, testified as neutral and submitted testimony #37092.

3:54 p.m. John R. Arnold, Deputy Commissioner, ND Insurance Department, testified as neutral and submitted testimony #37127.

Additional written testimony:
Amy Werremeyer, President, ND Pharmacists Association, submitted testimony in favor #36568.
Kathleen Nelson, Casselton Drug Pharmacy, submitted testimony in favor #37095.
William Kalanek, Lobbyist, Pharmaceutical Care Management Association, submitted testimony in opposition #37131.

4:16 p.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

I am writing to urge you to vote in favor of HB 1584!

Pharmacy Benefit Managers (PBMs) need to be held accountable! It is imperative that **HB 1584** is supported in order to do so! The ND Legislature has supported and passed some good PBM laws in recent years. It is time for meaningful enforcement of those laws. The ND Insurance Commissioner's office is the most appropriate place for enforcement of PBM laws. The Board of Pharmacy, ND Department of Health and Human Services could help the Insurance Commissioner's office through joint exercise of common powers agreements.

It is time that there is enactment of penalties if our valuable ND laws are not being followed! HB 1584 will do this, which will help to promote PBM compliance—much needed change for our North Dakotans who currently pay the price of PBMs' irresponsible and profiteering conduct.

Please do not hesitate to contact me should you have any questions or wish to further discuss.

Thank you,
Amy Werremeyer, PharmD, BCPP
2169 Victoria Rose Dr .S
Fargo, ND 58104

Testimony of Robert T. Smith,
Partner, Katten Muchin Rosenman LLP, and
Former Special Assistant Attorney General of North Dakota,

Before the Committee on Industry, Business and Labor,
North Dakota House of Representatives:

The State's Authority to Regulate Pharmacy Benefit Managers in the Wake of *Rutledge* and *Wehbi*

February 11, 2025

Chairman Warrey, thank you for providing me with an opportunity to testify before the House Committee on Industry, Business and Labor about the State's authority to regulate pharmacy benefit managers following the U.S. Supreme Court's decision in *Rutledge v. PCMA*, 592 U.S. 80 (2020), and the U.S. Court of Appeals for the Eighth Circuit's more recent decision in *PCMA v. Wehbi*, 18 F.4th 956 (8th Cir. 2021). As you know, *Rutledge* and *Wehbi* held that States may regulate PBMs even when those PBMs are serving plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA).

I am a partner at Katten Muchin Rosenman LLP in Washington, D.C., and a former special assistant attorney general for North Dakota, but I am appearing here solely in my individual capacity. Nothing I say here should be attributed to Katten or the Attorney General's Office. I also want to be clear that no one is compensating me for my time testifying here today. Nor did anyone compensate me for my time preparing to testify. I am here today at the invitation of the Chairman.

I have been involved in every major challenge to State PBM legislation for over a decade, including PCMA's challenges in *Gerhart* (852 F.3d 722 (8th Cir. 2017)),

Rutledge, *Wehbi*, and *Mulready* (78 F.4th 1183 (10th Cir. 2023), *pet. for cert. filed*, No. 23-1213 (U.S. filed May 15, 2024)). In some of those cases, I authored briefs on behalf of *amici curiae* defending the States' authority to regulate PBMs from challenges under ERISA and Medicare Part D. And in *Wehbi*, I led this State's successful defense of two North Dakota laws that regulate PBMs from challenges under ERISA. In that capacity, I twice argued in the Eighth Circuit, served as the principal author of the State's briefing at all levels of the federal judiciary, and successfully petitioned the Supreme Court to intervene when the Eighth Circuit reached the wrong result on the first go-round, and then helped the Eighth Circuit reach the right result on remand.

The results of these efforts—by many dedicated men and women in State AG offices across the country—is clear: The States possess robust authority to regulate PBMs even when those PBMs are serving plans subject to regulation under ERISA. You don't have to just take my word for it. The Supreme Court established as much in *Rutledge*, the Eighth Circuit extended those principles in *Wehbi*, and Texas Attorney General Ken Paxton recognized as much in a recent opinion letter about Texas's own efforts to rein in PBM abuses. *See* Tex. Att'y Gen. Op. No. KP-0480 (Feb. 5, 2025), https://www.texasattorneygeneral.gov/sites/default/files/opinionfiles/opinion/2025/kp-0480.pdf.

As I understand it, the Committee is currently contemplating legislation that would shift enforcement authority to the Commissioner of Insurance and make certain technical amendments to the definitions for a "covered entity" and a "pharmacy benefits manager."

I've divided my testimony into four parts: First, I will provide a brief overview of PBMs and State efforts to regulate those entities. Second, I discuss ERISA and the State's authority to regulate PBMs even when those PBMs are serving ERISA plans. Third, I will note how other States are handling enforcement authority and why it makes sense to charge the Insurance Commissioner and the Attorney General with authority to regulate PBMs. Finally, I explain why the Legislative Assembly should make certain technical amendments to the definitions for "covered entity" and "pharmacy benefits manager" contained in the North Dakota Century Code.

1. State Enforcement of PBM Laws

PBMs are powerful intermediaries who sit between patients and health plans. PBMs enter contracts with benefit plans and insurers to provide beneficiaries with access to prescription drugs. PBMs deliver this access by contracting separately with pharmacies to create networks where beneficiaries can fill their prescriptions. To be clear, PBMs are *not* health benefit plans. Rather, PBMs *sell* health benefit plans access to the pharmacy networks that PBMs create.

For many years, PBMs operated with impunity across the country, shielded by the false claim that any attempt by State governments to regulate their actions would yield to preemption by ERISA. PBMs originally were created to facilitate coverage determinations and quickly adjudicate prescription-drug claims at the pharmacy counter. Over time, PBMs developed an outsized role as the key financial middlemen in the prescription drug supply chain, establishing the prices that pharmacies would be paid, demanding kickbacks or rebates from drug manufacturers in exchange for

favorable formulary placement, and building pharmacy networks that determined which pharmacies could even participate in the marketplace.

Through consolidation and aggressive business practices, three PBMs now control over 80% of prescription drug reimbursements in the United States. These three companies have vertically integrated operations that include retail, mail order, and specialty pharmacies in direct competition with the pharmacies for which they establish reimbursement rates. PBMs have aggressively steered high-dollar medications to mail-order specialty pharmacies they themselves own, which has put their own interests above the plans and patients that PBMs purport to serve.

As PBMs have consolidated their grip over the prescription drug marketplace, their anticompetitive business practices have caused more than 7,000 pharmacies to close their doors just since 2019, according to data from a study at the University of Pittsburgh.[1] At the same time, prescription drug costs have skyrocketed even after adjusting for inflation.[2]

Seeking to take action to correct this trend of increasing prescription drug costs and decreased access to community pharmacies, nearly every State has now enacted legislation that regulates PBMs. These laws include requirements that PBMs apply for and maintain a license, regulating the process and amount of PBM-pharmacy reimbursements, the composition and quality of the pharmacy networks that PBMs

[1] https://apnews.com/article/pharmacy-closure-drugstore-cvs-walgreens-rite-aid-91967f18c0c059415b98fcf67ad0f84e

[2] https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#Nominal%20and%20inflation-adjusted%20per%20capita%20spending%20on%20retail%20prescription%20drugs,%201960-2021

create to sell access to insurers and benefit plans, and conflict of interests and predatory practices that PBMs impose on pharmacies.

2. ERISA and State Laws Regulating PBMs

For many years, there was substantial uncertainty about whether States could regulate third-party service providers, like PBMs, when they were serving plans subject to regulation by ERISA. A federal statute, ERISA regulates private employer- and union-sponsored welfare benefit plans, including prescription drug plans. In one early case, the U.S. Court of Appeals for the Fifth Circuit, which includes Texas, Louisiana, and Mississippi, held that ERISA preempts State insurance laws because they might have a tangential effect on ERISA plans. S*ee Texas Pharm. Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997). As a result, many States decided to regulate PBMs only when they were serving non-ERISA plans.

The Supreme Court's decision in *Rutledge v. PCMA*, 592 U.S. 80 (2020), rejected the logic that underpins those earlier decisions. In *Rutledge*, the Supreme Court considered a challenge to an Arkansas law that regulates PBMs. Act 900, as Arkansas's law is known, regulates the amounts PBMs reimburse pharmacies for generic drugs; requires PBMs to provide a reasonable administrative appeal procedure, and to update and disclose their reimbursement lists to pharmacies; and allows pharmacies to decline to dispense drugs to beneficiaries when a PBM intends to reimburse the pharmacy less than the pharmacy's cost to acquire the drug. Ark. Code Ann. § 17-92-507. PCMA, a trade association representing the eleven largest

PBMs, claimed that ERISA preempts Act 900. A unanimous Supreme Court disagreed.

According to the Supreme Court, ERISA preempts State laws that have a "connection with" or "reference to" ERISA plans. *Rutledge*, 592 U.S. at 86. A State law has a "connection with" ERISA plans when it "governs a central matter of plan administration or interferes with national uniform plan administration." *Id.* at 87. A State law has a "reference to" ERISA plans if and only if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Id.* at 88.

The Supreme Court held that Act 900 did not have a forbidden "connection with" ERISA plans. *Id.* at 87-88. In so holding, the Court emphasized that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan." *Id.* at 87. Rather, ERISA is "primarily concerned with preempting [State] laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status." *Id.* at 86-87. Thus, the Supreme Court has deemed preempted State laws that dictate eligibility or benefits contrary to the terms of an ERISA plan. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (eligibility); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (benefits); *accord Rutledge*, 592 U.S. at 87. Act 900 does none of these things. The Court explained that the main part of Arkansas's law was a form of "cost regulation," which does not force ERISA plans "to adopt any particular

scheme of substantive coverage." *Id.* at 88. Similarly, the Court held the law's "enforcement mechanisms"—the appeal, update, and decline-to-dispense provisions—simply regulate the relationship between PBMs and third parties that sell access to the "medical benefit[s]" that plans ultimately provide to their beneficiaries. *Id.* at 89-90. The Court emphasized that State law has traditionally governed the relationship between plans and third parties who happen to sell goods and services to ERISA plans. *See id.*

The Court also held that Act 900 did not make a prohibited "reference to" ERISA plans. *Id.* at 88-89. "Act 900 does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan." *Id.* at 88. And "ERISA plans are likewise not essential to Act 900's operation," because "Act 900 regulates PBMs whether or not the plans they service fall within ERISA's coverage." *Id.* at 89.

To summarize, *Rutledge* clarifies that States may regulate PBMs even when PMBs are serving ERISA plans, and ERISA preemption is concerned primarily with State laws only when they "requir[e] payment of specific benefits" or "bind[] plan administrators to specific rules for determining beneficiary status.'" *Id.* at 87. Typical State laws regulating PBMs do neither of these things.

In *PCMA v. Wehbi*, the Eighth Circuit extended the reasoning of *Rutledge* to apply to two North Dakota laws that regulated the accreditation standards that PBMs impose upon pharmacies, a PBM's ability to refer patients to PBM-affiliated pharmacies, and other aspects of how PBMs design the pharmacy networks to which

they charge health plans for access. 18 F.4th 956 (8th Cir. 2021). In that case, PCMA argued the laws impermissibly regulated "benefit design" by limiting the range of choices plans can make in their interactions with PBMs and pharmacies. PCMA Replacement Br. 22-27, 31, *PCMA v. Wehbi*, No. 18-2926 (8th Cir. May 11, 2021), 2021 WL 2022000. But the Eighth Circuit held that ERISA does not preempt these PBM-network provisions, emphasizing that they "do not 'requir[e] payment of specific benefits' or 'bind[] plan administrators to specific rules for determining beneficiary status.'" *Wehbi*, 18 F.4th at 968 (quoting *Rutledge*, 592 U.S. at 87).[3]

3. The Appropriate Entity to Enforce State PBM Laws

As a general matter, most States have charged their insurance commissioner or attorney general (or both) with authority to regulate PBMs. For example, Texas, Arkansas, Louisiana, and Tennessee have all regulated PBMs within their insurance codes and given far-reaching authority to their insurance commissioners. *See, e.g.*, Tex. Ins. Code §§ 1369.551–.555, §§ 1369.601–.610; Ark. Code § 23-92-505; La. Rev. Stat. § 22:1657; Okla. Stat. §§ 36-6958 – 36-6968; Tenn. Code Ann. § 56-7-3113.

North Dakota is somewhat unique in giving six different agencies or executive officials a role in regulating PBMs: the Attorney General, the Board of Pharmacy, the Department of Health and Human Services, the Insurance Commissioner, the Public Employees Retirement Board, and the State's Attorneys.

[3] To be clear, even where ERISA preempts a State law, that law is preempted "only insofar as [it] relate[s] to plans covered by ERISA." *Shaw*, 463 U.S. at 97 n.17. That means that ERISA does not preempt State laws as applied to non-ERISA plans, including government-sponsored plans.

In my opinion, the State might benefit from consolidating most of its enforcement powers with the Insurance Commissioner and the Attorney General. A few thoughts inform this opinion.

Although PBMs are not risk-bearing entities, the three largest PBMs are vertically integrated with large health insurance companies that do bear risk and are subject to traditional regulation by the insurance commissioner. When viewed in the appropriate context, PBMs are simply an extension of how many health insurers ultimately administer fully insured pharmacy benefits. And even when a PBM is acting as a third-party administrator on behalf of a self-insured plan, a PBM is providing the same services that it provides to fully insured plans. The insurance commissioner is best positioned to understand and regulate the plan- and beneficiary-facing sides of a PBM's business.

In addition, ERISA provides the States with more authority to regulate PBMs when the State is regulating insurance. Under ERISA's insurance savings clause, even when a State law makes an impermissible connection with ERISA plans, nothing in ERISA shall be "construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). At the same time, under the so-called deemer clause, an ERISA plan "shall not be deemed to be an insurance company" subject to "any law of any State purporting to regulate insurance companies." *Id.* § 1144(b)(2)(A). According to the United States government, the net effect of these two provisions is to allow States to regulate PBMs under their insurance codes even when those PBMs are applying services to ERISA plans, but a

State cannot regulate ERISA plans directly. *See* Br. of United States as *Amicus Curiae* 17-20, *PCMA v. Mulready*, No. 22-6074 (10th Cir.) (filed Apr. 10, 2023), *available at* 2023 WL 2990378.

According to the Supreme Court, a State law need only be directed towards the insurance industry and affect the risk-pooling arrangement between an insurer and its insured to qualify under the savings clause. *Miller v. Ky. Ass'n of Health Plans, Inc.*, 538 U.S. 329, 334, 338 (2003). As a result, regulating PBMs under the insurance code does two things: It matches the reality that PBMs are often integrated with insurers and regulations of PBMs often affects the risk pooling arrangements of the insurance that is offered, and it further insulates State laws from claims of ERISA preemption.

All that said, there are still benefits to providing the Attorney General with some authority over PBMs. Among other things, PBMs enter business transactions with pharmacies, pharmaceutical manufacturers, other businesses, and governments. As a result, there also is a role for the Attorney General in ensuring that PBMs do not engage in abusive business practices with these entities.

4. The Need for Technical Amendments

As I understand it, the proposed legislation before this Committee would make technical amendments to the definitions for "covered entity" and "pharmacy benefit manager." Among other things, the Committee has proposed striking exemptions from these definitions for self-funded plans subject to regulation under ERISA. The Committee is right to pursue these changes.

Unfortunately and somewhat counter-intuitively, the Eighth Circuit has twice held that where a State law includes an express exemption for self-funded plans, ERISA will preempt that State law in all of its applications—even as applied to fully insured ERISA plans—because such a provision bears an express reference to ERISA. *See Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 154 F.3d 812, 822-26 (8th Cir. 1998); *see also PCMA v. Gerhart*, 852 F.3d 722, 728-29 (8th Cir. 2017), *abrogated on other grounds by Rutledge v. PCMA*, 592 U.S. 80 (2020). Although the Supreme Court has since rejected other aspects of the Eighth Circuit's ERISA jurisprudence, it has not reviewed the Eighth Circuit's express-reference holding in *Prudential* or *Gerhart*.

As a result, there is a substantial risk that the Eighth Circuit would strike down North Dakota's PBM laws in their entirety as applied to ERISA plans if North Dakota continues to exempt self-funded plans subject to regulation under ERISA. It is therefore critical that the legislature remove the express reference to self-funded ERISA plans from the North Dakota Century Code.

That said, I understand that the Insurance Commissioner has expressed some uneasiness about regulating self-funded ERISA plans directly to the extent that they are self-administering their own pharmacy benefits. Some of this uneasiness may be traced back to an early view of the scope of ERISA preemption—a view that the Supreme Court has since refuted.

Nevertheless, there is an easy solution for this concern. The Committee can modify the definition of "pharmacy benefit manager" to clarify that it applies only to

persons or entities that perform pharmacy benefit management, as a third party, under a contract or other financial arrangement with a covered entity. Doing so would address the Commissioner's apparent concern about regulating self-funded plans that administer their own pharmacy benefits while avoiding the Eighth Circuit's line of decisions that prohibits States from including an express exemption for self-funded ERISA plans.

In addition, changing the definition as proposed could further insulate North Dakota's laws from legal challenge. Although the Eighth Circuit has held that the regulation of a PBM is effectively the regulation of an ERISA plan when a PBM is serving an ERISA plan, *see Wehbi*, 18 F.4th at 966-67, the Supreme Court has not blessed this approach—and there are reasons to believe the Supreme Court might decline to do so. In *Rutledge*, for example, the Supreme Court explained that State law governs a plan's relationship with third-party service providers, and PBMs should not be viewed as an exception to this rule. 592 U.S. at 90-91. Similarly, in *Metropolitan Life Insurance Co. v. Massachusetts*, the Supreme Court clarified that that "laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans" under ERISA and are therefore not preempted by that law. 471 U.S. 724, 741 (1985). Because an insurer is a third party that sells a service to ERISA plans, it is possible to view this language to extend to laws that regulate only PBMs. Moreover, the Trump Administration previously supported this distinction in *Rutledge*, explaining that Arkansas's law did not trigger concerns under ERISA because it "regulates PBM administration, not ERISA plan administration."

Br. of United States as *Amicus Curiae* 15, *Rutledge v. PCMA*, No. 18-540 (U.S. Dec. 4, 2019), *available at* 2019 WL 6609430.

As a result, the Committee might consider changing the definition of "pharmacy benefit manager" to read:

> "Pharmacy benefit manager" means a person who performs pharmacy benefits management, as a third party, under a contract or other financial arrangement with a covered entity. The term does not include a health benefit plan that manages its own pharmacy benefits.

* * * * *

In the wake of *Rutledge*, there is growing consensus that States should exercise their authority to regulate PBMs—regardless of the type of plan that the PBM is serving. Even before the Supreme Court decided *Rutledge*, the federal government, forty-six States, and the District of Columbia filed briefs with the Supreme Court arguing that States have robust authority to regulate PBMs.

As a result, there has been a recent surge of State-level regulation of PBMs, and the push for such regulation has straddled the political divide. Red States and Blue States—from Arkansas to California, and everywhere in between—have enacted or are considering legislation to further regulate PBMs. North Dakota should continue to lead the charge by making common-sense tweaks to its existing law.

I am happy to answer any of the Committee's questions.

GREATER NORTH DAKOTA CHAMBER
HB 1584
House Industry Business & Labor Committee
Chair Jonathan Warrey
Feb. 11, 2025

Mr. Chairman and members of the Committee, my name is Arik Spencer, President and CEO of the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** to House Bill 1584.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing state government could do to help your business, the top answer was to make healthcare more affordable.

HB 1584 seeks to put self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity," subjecting them to state-imposed healthcare mandates, which will increase their healthcare costs.

According to North Dakota health insurers, each biennium, healthcare mandates cost employers in the small and large group pool in excess of $800,000,000 in increased premiums. Just last fall, the Insurance Commissioner approved small group insurance premium increases between 6.3% and 15.3% for the 2025 plan year. These increases leave employers with hard decisions. Do they continue offering employer-sponsored health insurance or do they provide raises to help employees pay for rent and groceries?

Should the current version of HB 1584 become law, self-funded plans that organize to control their costs would likely be subject to all state-level mandates already imposed on employers in small and large group plans, drastically increasing their costs. It's important to note that there are eight other bills this session proposing mandates that would either be applied to the private sector or require a bill to apply to the private sector in the next session. These costs add up, and they don't go away.

GNDC strongly urges a DO NOT PASS recommendation, and I will be happy to stand for questions.

STATE OF NORTH DAKOTA
GOVERNOR DOUG BURGUM

NORTH DAKOTA STATE BOARD OF PHARMACY
OFFICE OF THE EXECUTIVE DIRECTOR

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Bill No 1584 -Pharmacy Benefits Managers

House Industry, Business and Labor Committee- 327C
2:30 P.M. - Tuesday – February 11th, 2025

Chairman Warrey, members of the House Industry Business & Labor Committee, for the record I am Mark J. Hardy, PharmD, Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today about House Bill 1584.

The Board of Pharmacy members have long been concerned on the practices of **P**harmacy **B**enefit **M**anagers [PBM] and many patient care issues created by the market powers of PBMs. We continue to hear from patients and pharmacies with concerns of PBM models impacting delivery of care. Our office has watched the growing number of states that enacted meaningful regulatory approaches on PBMs to enforce laws to address market concerns which PBMs influence.

North Dakota was an early adopter of the certification/licensure of PBMs through the Insurance Commissions Office. Laws and court rulings on PBMs have impacted the provisions listed in the original law, which we understand is leading to HB 1584. The state should strongly consider strengthening the regulatory mechanism to enforce those provisions over PBMs to protect the patients in our state.

Our office certainly will be happy to be a partner to the Insurance Commissioner's Office in any capacity if these changes are enacted. I will be happy to answer any questions you may have and do appreciate your time.

Yes on HB 1584

I am writing in support of this bill. I own and operate 2 rural pharmacies in North Dakota, and we need to enforce these rules we have made already for PBMs. We have some good laws- why not enforce them with penalties?

HB 1584 will help to enforce PBM compliance. Congress is taking up laws to pass PBM reform nationwide, so this just makes sense in North Dakota.

Thank you for your consideration.

Kathleen Nelson, RPh., owner
Casselton Drug and Arthur Drug
North Dakota

February 11, 2025

The Honorable Jonathan Warrey
ND House Committee on Industry, Business and Labor

Via Online Testimony Submission: https://ndlegis.gov/legend/committee/testimony/public-testimony/4528/?hearing=12031

RE: HB 1584: A BILL for an Act to create and enact two new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to provide a penalty; and to declare an emergency: Oppose

Dear Chair Warry and Members of the House Committee on Industry, Business and Labor:

Thank you for the opportunity to comment on HB 1584. I represent Prime Therapeutics (Prime), a pharmacy benefit manager (PBM) owned by 19 not-for-profit Blue Cross and Blue Shield Insurers, subsidiaries, or affiliates of those Insurers, including Blue Cross & Blue Shield of North Dakota. HB 1584 seeks remove the ERISA exemption Section 26.1-27.1-01 of the North Dakota Century Code. It is for this reason, among others that Prime opposes this legislation.

Prime helps people get the medicine they need to feel better and live well by managing pharmacy benefits for health plans, employers, and government programs including Medicare and Medicaid. Our company manages pharmacy claims for more than 30 million people nationally and offers clinical services for people with complex medical conditions. Our business model relies on transparency and advocating for simpler, lowest-net-cost pricing for drugs. Importantly, Prime is not focused on driving profit margins.

What is the intent of this bill?
Based on previous testimony in this committee for a separate bill, it appeared there was some interpretation of past court decisions that somehow allows for the removal of an exclusion to self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA). Regardless of interpretation, I don't understand the reasoning behind the removal. This simply strips those protected entities in the state of North Dakota from choosing the right benefits for their company/employees. This will drastically increase costs for those businesses and their employees. Why? Proponents of the bill will argue that this somehow holds Pharmacy Benefit Managers (PBMs) "accountable." How? Employers send PBMs their benefit book, and we implement it. By prohibiting the function of the PBM to implement the benefit, the legislation is prohibiting the employer from choosing the benefit design that works for them. This law would require the enforcing entity to contact each employer to inform them they can or cannot choose their desired benefit for their business and their employees. Prime Therapeutics believes in these protected groups' rights to choose the right benefit for their employees, and these businesses are protected under federal law.

Extraterritoriality Factor
Extraterritoriality refers to the application of a nation's law to persons, conduct, or property outside its own territory. For arguments sake, let's say this law passes. Let's also say I have a business in Illinois (Illinois decides to pass this same law) with employees in North Dakota. Under Illinois state law, I must cover Mifepristone and Misoprostol. My employees in North Dakota can now go to a pharmacy in North Dakota and fill this prescription. The idea here is that extraterritoriality cuts both ways. This is the very reason for the ERISA exemption. What happens when every state does the same thing? What trumps what?

26.1-27.1-04. Prohibited Practices
(3) states "A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond to respond and signatures must be obtained from the pharmacy or entities contracting on

behalf of pharmacies." This language does not consider instances where state and/or federal law may require immediate amendments to contracts. This may require a signature earlier than 30 days. The same would be true for (4) "A pharmacy must be allowed to opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice."

Section 6: Enforcement
(3) "This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements." There is no definition of "collaboration through joint exercise of common powers agreements" in this legislation. I would like to understand from the writers of this legislation what that means.

Thank you again, for allowing me the opportunity to testify today.

Respectfully,

Marcus Caruso
Government Affairs, Prime Therapeutics
Cell: 612.845.9870 | Email marcus.caruso@primetherapeutics.com

NORTH DAKOTA
Insurance Department

HB 1584 NEUTRAL TESTIMONY

John Arnold, Deputy Commissioner

House Industry, Business and Labor Committee
February 11, 2025

Good afternoon, Chairman Warrey and members of the House IBL committee.

My name is John Arnold, Deputy Insurance Commissioner, and I'd like to thank you for hearing our Department's neutral testimony for House Bill 1584.

When considering what action to take in regulating Pharmacy Benefit Managers (PBMs), I urge the committee to first consider the goal of the regulation. Is the regulation intended to protect consumers, or is it intended to protect pharmacists? I am not suggesting that one of these goals is superior to the other, but the answer to the question should guide the regulatory discussion.

If the goal is to protect consumers, namely through the reduction in prescription drug prices, I am compelled to inform you that the experience of the handful of states that have been leaders in PBM regulation have not seen this goal come to fruition. This isn't to say that some form of regulation may be successful in attaining that goal, but we haven't yet seen what that regulation looks like. So, if the goal is to lower prescription drug prices, I would encourage your consideration to resist the urge to act and further explore possible avenues to do this.

If, however, the goal is to protect pharmacists and pharmacies, this type of regulation may be beneficial. Some of the states that have been early adopters of PBM regulation have seen pharmacists and pharmacies receive increased payment from PBMs. But again, consumers have not seen the direct benefit of this sort of regulation.

I believe that the answer to the question of what the goal of the regulation is vital because it should then inform which entity would be appropriate for implementing the regulation. The Insurance Department is first and foremost a consumer protection agency. We regulate the insurance industry from the perspective of safeguarding promises made to North Dakota's insurance consumers. While PBMs certainly interact with insurance companies, it is important to remember that they are neither insurance companies nor insurance producers. They currently license as a third-party administrator, however that is to allow them to provide insurance companies with administrative services, not to pool and underwrite risk.

If the goal of the regulation is to protect pharmacists, then I would suggest that an entity that is more familiar with pharmacists, pharmacies, and the pharmaceutical industry may be the better fit. Given that, it may be appropriate for the legislature to consider whether it may be appropriate to evolve the Board of Pharmacy, perhaps to the extent of making it a state agency to alleviate conflicts of interest concerns that may arise from that entity regulating to the benefit of the members of the board, into a body that could license, regulate, and enforce PBMs.

As drafted, HB 1584 also includes the regulation of PBMs to include full compliance with chapter 19-02.1, the North Dakota Food, Drug, and Cosmetic Act. The Department of Health and Human Services already has enforcement authority for this chapter, including partial PBM regulation found in sections 16.1, 16.2, 16.3, and 16.5.

As drafted, HB 1584 recognizes that these three entities all currently have some touchpoint with PBMs, as seen on page 5, lines 6-8. I respect the effort to utilize existing state resources rather than adding FTEs but relying on joint exercise of common powers agreements has two notable flaws. First, a lack of leadership. As drafted, the Insurance Commissioner is responsible for the implementation of HB 1584, however the Commissioner has no authority over the staff of the Department of Health and Human Services or the Board of Pharmacy. The Commissioner cannot address prioritization or work, scheduling, or performance issues in those agencies as it relates to duties of this bill. Second, the experience of other states has shown that the volume of work that such regulation requires dedicated staff. States that have passed laws, such as this bill, without dedicated staff have had to add those staff at the subsequent legislative session.

I've testified in the past that the necessary resources rely less on the population of the state, and more on the population of PBMs, which is roughly even across the country. While our lower population than many states may well correlate with fewer prescriptions being filled, the number of complaints is less important than the grouping of the complaints by PBM and by type are likely uniform.

For example, last weekend I attended a conference and the Insurance Commissioner from Kentucky mentioned that in January alone her office received over 3,000 complaints. Given that North Dakota's population is approximately 17% of Kentucky's population, we could still anticipate well over 500 complaints a month. Having staff sort the complaints is perhaps the only portion of the process that depends on population. One or two individuals may be able to process that volume of incoming complaints. Once sorted, we would envision needing a pharmacist and one or two attorneys to review the complaints and interact with PBMs. Additionally, we would anticipate the need for a company analyst and a fraud analyst. Irrespective of whether the Insurance Department fulfills this regulatory need or some other entity, we suggest that effective regulation requires five to seven dedicated staff. This is not an endeavor that can be spread between the existing staff of three separate entities.

In addition to the broader issues detailed above, there are two other points that need to be considered as you look at HB 1584. First is the oversight of not creating a separate license of PBMs. Under HB 1584 as introduced, PBMs would continue to hold a third-party administer license. This is problematic because of the 250-plus third-party administrators that we license, I cannot tell you how many of them are PBMs. The lack of clarity in licensing has caused issues in at least one other state, and I would suggest that we learn from that mistake.

Lastly, there is the Rutledge issue. I stand before you today not to imply that I have an opinion on the authority granted by Rutledge, nor to propose that the threat of a lawsuit should impact your decision as legislators, but just to suggest that since the courts seem to still be in the process of determining the full impact of the Rutledge ruling it may be prudent to amend the bill to state that the Attorney General is responsible for any litigation that may arise from the implementation of HB 1584, or appropriate funding with which the entity that is ultimately tasked with this regulatory authority can rely on for Attorney General representation.

Thank you, Chairman Warrey and members of the committee. I am happy to try to answer any questions that you may have.

House Industry, Business and Labor Committee
HB 1584
February 11, 2025 - 2:30 pm

PCMA Testimony in Opposition to HB 1584

GOOD AFTERNOON CHAIRMAN WARREY, VICE CHAIRMAN JOHNSON AND COMMITTEE MEMBERS:

My name is Michael Power and I represent the Pharmaceutical Care Management Association also referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

At this time, PCMA appreciates the opportunity to provide comments on HB 1584 and respectfully opposes it. This bill changes existing law by making changes to definitions, adding to the list of pharmacy benefit manager prohibited practices, and adds enforcement and penalties for noncompliance.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

In 2020, the cost of health care spending per North Dakota resident was $13,204, which ranks it as the 15th highest in the country[1]Health care costs are already high in North Dakota, and enacting HB 1584 will only exacerbate the problem.

The proposed legislation will change existing North Dakota law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity." The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates, leading to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for their employees. The legislation could mean that current anti-business laws would now apply to the self-funded market and could cost self-funded health plans in the State of North Dakota **$25 million in excess drug spending in the first year alone and $417 million over the next 10 years**.

It should be noted, the U.S. Supreme Court's 2020 decision in the *Rutledge* case was clear and followed 50 years of federal preemption jurisprudence. States may only regulate self-funded health plans organized under federal ERISA law in very narrow circumstances.

[1] USA Facts. "Health in North Dakota." 2023.

In 2021, the U.S. Court of Appeals for the 8th Circuit ruled via the *Wehbi* case that certain North Dakota anti-PBM laws may be applied to ERISA plans. However, it should be noted that **a state would not be compelled to regulate said plans**. PCMA believes the *Wehbi* decision was wrongly decided, and may embolden bad public policy, including anti-business laws.

PCMA also has concerns with the additional language added under the definition of "Payment received by the pharmacy benefits manager". For example, "pharmacy price concessions" was added, however, pharmacies do not pay PBMs pharmacy price concessions.

In Section 3, under "Prohibited practices", we also have concerns with the added language dealing with opt-in contracts. There are times in the renewal process when getting a signed contract back from a pharmacy in a timely manner is an issue. This could put both patient access and network adequacy at risk.

In Section 6, dealing with "Enforcement", the new language would allow 'collaboration' with the state board of pharmacy. There is a great need to ensure the protection of competitive and proprietary financial information. Therefore, we are **very concerned** about data and information being shared with the board of pharmacy. It should be noted that the Federal Trade Commission (FTC) has opposed regulatory boards composed of market participants in other industries. There is also a US Supreme Court case in *North Carolina State Board of Dental Examiners v. Federal Trade Commission,* that looked into the question and ruled in favor of the FTC. The Board of Pharmacy is comprised of active market participants whose access to market sensitive data could result in a conflict of interest and undermine competition in the prescription drug marketplace.

Finally, in Section 7, dealing with "Administrative penalties" the monetary and civil penalties are extremely excessive, and the language pertaining to restitution to individuals is puzzling given PBMs do not have direct contracts with individuals/members.

It is for these reasons we are opposed to HB 1584 and we recommend a "do not pass" recommendation.

Thank you for your time and consideration. I would be happy to answer any questions.

North Dakota HB 1584 to Cost the State $417 Million In Increased Prescription Drug Costs

In 2020, health care spending cost $13,204 per North Dakota resident, ranking it the 15th highest-spending state on healthcare.[1] In that same time, North Dakota spent over $289 million on retail prescription drugs in the commercial market.[2] Health care costs are already high in North Dakota, and HB 1584 would only contribute to the problem. The proposed legislation would change existing North Dakota law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity." The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates, leading to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for employees. The legislation could mean the current anti-business laws would now apply to the self-funded market.

The core mission of pharmacy benefit managers (PBMs) is to reduce prescription drug costs for health plan sponsors so that consumers have affordable access to needed prescription drugs. PBMs offer a variety of services to their health plan sponsor clients and patients that improve prescription adherence, reduce medication errors and manage drug costs.

Current North Dakota law includes provisions to restrict the use of core PBM tools, including preferred pharmacy networks, utilization management tools, and white bagging. Although some of the provisions are subject to interpretation, expanding just the provisions discussed below to self-funded health plans could cost the State of North Dakota **$23 million in excess drug spending** in the first year alone and **$417 million** over the next 10 years.

Projected 10-Year Increases in Prescription Drug Spending in North Dakota, 2025–2034 (millions)

	Self-Insured Group Market
Restrict Pharmacy Networks	$196
Restrict Utilization Management Tools	$97
Restrict White Bagging	$125
Maximum Costs – Three Provisions	**$417**

Methodology: The methodology used to create these cost projections for adopting AWP and utilization management tools was that used by Visante in the January 2023 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools." The methodology used to create the white bagging cost projections is described in "Appendix: White Bagging Dispensing."

[1] USA Facts. "Health in North Dakota." 2023.

[2] PCMA acquired IQVIA data. The statements, findings, conclusions, views, and opinions contained and expressed in this report are based in part on data obtained under license from the following IQVIA Institute information service: IQVIA PayerTrak data for PCMA, 2022, IQVIA Inc. All Rights Reserved.

PCMA

Bill Provisions Descriptions

Expanded restrictions could limit the use of preferred pharmacy networks, specialty pharmacies, and mail-order pharmacies.

- PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Pharmacies that agree to participate in such arrangements are designated as 'preferred' and become members of a preferred pharmacy network. These types of networks have gained traction among plan sponsors and deliver tangible savings for patients.
- Nearly 80% of employers believe that mail-order specialty pharmacies are the lowest-cost site of service compared with retail community pharmacies and other options.[3] The bill guts the ability for health plans and PBMs to create preferred pharmacy networks for plans by mandating an "any willing provider"(AWP) requirement. According to the Federal Trade Commission[4] and academic analysis,[5,6,7] this type of mandate leads to less competition and higher prices for consumers.
- When applied to specialty pharmacies, the consequences of AWP legislation are even greater. Because specialty drugs are dispensed in such low volumes and target rare conditions, it is infeasible for most retail drugstores to stock these medications and provide the specialized services patients require. States do not legally differentiate specialty pharmacies from traditional pharmacies. These payer-aligned specialty pharmacies must meet payers' terms and conditions to be included in preferred pharmacy networks. Of the roughly 64,000 pharmacies in the U.S., only about 400—less than 1%—are accredited as specialty pharmacies by the independent Utilization Review Accreditation Commission.[8]

Expanded restrictions could limit PBM utilization management tools.

- Utilization management tools like prior authorization and step therapy are widely used by PBM clients to help ensure appropriate and cost-effective use of high-cost drugs. Studies have demonstrated that prior authorization can generate savings of up to 50% for targeted drugs or drug categories.[9] Step therapy has demonstrated savings of more than 10% in targeted categories. These tools are becoming increasingly important in managing the rapidly growing use of high-cost specialty pharmaceuticals. Restricting the use of these tools would raise drug benefit costs for both patients and plan sponsors.

Expanded restrictions could expand the ban on white bagging.

- Under a white bagging model, a specialty pharmacy ships the drug for a given patient directly to the health care provider rather than the provider buying the drug and billing the insurer. The cost of these drugs through specialty pharmacies is lower than through the traditional "buy-and-bill" model.
- Legislation that would bar health insurers from implementing white bagging will seriously undermine the ability of health plans and PBMs to manage their medical specialty pharmacy expenditures, and as a result, drug spending in North Dakota would soar. The use of white bagging has real benefits for patients, providers, and health plan sponsors.

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[3] PBMI. "Trends in Specialty Drug Benefits". 2018.
[4] FTC letter to CMS. "Contract year 2015 policy and technical changes to the Medicare advantage and the Medicare prescription drug benefit programs." Mar. 7, 2014.
[5] Klick, Jonathan and Wright, Joshua D., "The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures." Am. L. & Econ. Rev. 192 (2015).
[6] Atlantic Economic Journal. Durrance, C., "The impact of pharmacy-specific any-willing-provider legislation on prescription drug expenditures." 2009.
[7] DHS. Reforming America's Healthcare System Through Choice and Competition. 2018.
[8] URAC. "2022 Specialty Pharmacy Performance Measurement." 2023.
[9] Prime Therapeutics. "Specialty Utilization Management Proves Effective: Ampyra Prior Authorization Improves Safety and Saves Money." 2011.

North Dakota HB 1584 ONLY leads to Increased Prescription Drug Costs

Health care costs are already high in North Dakota, and HB 1584 would only contribute to the problem and increase costs.

- The proposed legislation would change existing law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity."
- The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates.
- This would lead to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for employees.
- The legislation could mean the current anti-business laws would now apply to the self-funded market.
- While some of the provisions are subject to interpretation, it is estimated this could cost self-funded health plans **$23 million in excess drug spending** in the first year alone and **$417 million** over the next 10 years.

GNDC Greater North Dakota Chamber

PCMA

NDAREC's North Dakota Association of Rural Electric Cooperatives Your Touchstone Energy® Cooperative

NORTH DAKOTA BANKERS ASSOCIATION

ICBND INDEPENDENT COMMUNITY BANKS of NORTH DAKOTA

House Bill 1584
North Dakota House Committee on Industry, Business, and Labor
February 11, 2025
AHIP Testimony

Thank you for the opportunity to speak before you today. My name is Alex Kelsch, and I am testifying on behalf of America's Health Insurance Plans (AHIP). [1]

AHIP appreciates the opportunity to comment on HB 1584. AHIP is opposed to this bill because we are concerned several provisions in HB 1584, due to the definitional change of "covered entity," are preempted by ERISA.

AHIP has provided a legal analysis by the Groom Law Group to the committee supporting this position, which includes a discussion of the ERISA and jurisprudence landscape, a description of the specific provisions included in HB 1584 of concern, and the basis for federal preemption.

AHIP strongly opposes any attempt to regulate ERISA self-funded plans beyond the limits allowed under federal preemption law and jurisprudence. Should the proposed policies be enacted, this bill could jeopardize the cost-saving, uniform standards North Dakota's self-insured ERISA employers rely upon to provide affordable health insurance coverage to their employees.

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to incentivize employers to offer robust coverage to employees across the country, which is the leading source of affordable, comprehensive, and high-quality health coverage in the U.S.

A key feature of ERISA is that it established uniform standards that apply to all employees and their beneficiaries – including those residing in different states. These uniform standards enable health plans and employers to provide affordable, consistent and equitable coverage to all of their employees and their dependents.

Today, more than half of Americans receive their health insurance through employer coverage that is governed by ERISA, which affords employers consistency and uniformity of health plan administration. This encourages health care coverage that improves the health and financial stability of employees and their families. In North Dakota, nearly 500,000 residents (65% of the state's population) are covered by employer insurance. Of those North Dakota employers that provide coverage to their employees, 57% of those employers offer self-insured ERISA plans to roughly 282,000 North Dakotans.[2]

AHIP supports a single, cost-saving national standard of regulation for employer-provided health care coverage – one that gives employers the option to assume financial risk and allows employers to choose specifically tailored and uniform benefits for their employees

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[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.
[2] https://www.ahip.org/documents/2023-AHIP_StateDataBook-ND.pdf

regardless of where they live. This ensures more affordable coverage that is easier to administer and understand.

The alternative, a 50-state patchwork of complicated and inconsistent mandates for employer provided coverage, would cause confusion, and make coverage more expensive for North Dakota employers and employees. Concerns with the imposition of varied state-by-state mandates include that they would lead to consequences such as:

- Increased costs for North Dakota employers;
- Increased costs for employees, families and consumers;
- A more complicated health insurance system;
- More red tape and bureaucracy in the health care system;
- Inequal access to care as employees in different states would have different "tiers" of health insurance coverage.

Thank you for your consideration of our concerns. To protect North Dakota employers from increased health care costs, AHIP urges you to not to pass HB 1584.

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House Industry, Business and Labor Committee
HB 1584 – 2/11/25 – 2:30pm
Rep. Jonathan Warrey – Chairman

Chairman Warrey and members of the House Industry, Business and Labor committee, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1584.

HB 1584 looks to address a legal concern, changes to the marketplace and how can North Dakota create a better process for enforcing existing PBM laws. As discussed previously, it is not just our opinion that we should change the existing PBM law in front of us. In the very first definition (covered entity), explicitly exempting self-funded ERISA plans in the law, could preempt the entire law. I have summarized the two 8th Circuit cases below that deal with a state law when it exempts ERISA self-funded plans by reference in the law.

1ST Case - Prudential Ins. Co. of Am. v Nat'l Park Med. Ctr., Inc. 154 F.3d 812, 822-26 (8th Cir. 1998)

The court concluded, first, that if a state law contains a "reference to" ERISA plans by singling out such plans for special treatment, such as, an exemption from the law, there is an established "reference to" and therefore preempted under federal law (the law in its entirety).

2nd Case – PCMA (PBMs) v. Gerhart (Iowa) 852 f.3d at 729 (8th Cir. 2017)

The same logic from 1998 was used in this PBM case. Iowa passed some PBM laws and in the laws, they exempted self-funded ERISA plans from the law. Because Iowa had a "reference to" ERISA plans in their law, even though it was to exempt them from the law, the State of Iowa lost to the PBMs. The laws were preempted under ERISA because they had a "reference to" ERISA by explicitly exempting self-funded ERISA plans in their law. Crazy I know and I do not agree with the 8th Circuit, but that has been their position twice. The US Supreme Court has never addressed the 8th Circuit position related to directly exempting ERISA plans causes federal preemption. The 8th Circuit's

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standard for an express reference to ERISA therefore remains good law. This is why it is important to remove language that directly exempts ERISA plans.

Opinion letter by Attorney General Paxton (TX) concluding that ERISA does not preempt two recent Texas laws that regulate PBMs: (February 5, 2025)
https://www.texasattorneygeneral.gov/opinions/ken-paxton/kp-0480?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

The opinion is helpful in a number of ways: First, I think it is a well-reasoned analysis of why ERISA does not preempt the PBM laws at issue in Texas. Second, you will notice in his opinion, Paxton sights PBM laws in Texas where there is no reference to ERISA in the PBM laws. Therefore, the laws are not preempted and last, it comes from AG Paxton, a conservative heavy weight.

On page 2 – Lines 5-6

Language is added to include rebate aggregators. What is a rebate aggregator? A rebate aggregator is often owned by the PBM or affiliated with the PBM. Two of the three main rebate aggregators are located outside the United States with one being Ireland and the other in Switzerland. We feel most of the rebate model has shifted in favor of rebate aggregators. If we are asking for information on rebates, it is important to note the rebate aggregators that the Big 3 now own.
Plan Sponsor ALERT: Beware of Rebate Aggregators

FTC Expands PBM Investigation to PBM-Owned Rebate Aggregators/GPOs

Language is also added to verify how much of the rebate dollars were retained by the PBM.

Page 2 – Lines 21-22

Since this law was enacted, we have seen a lot of market changes, especially around fees pharmacies pay to PBMs. From 2010 to 2020, PBM fees charged to pharmacies increased 91,000%! That is not a typo. We would like to see price concessions that are paid to the PBM also be reported.

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According to the fiscal year 2022 budget justification (p.242) estimate sent to Congress by CMS, pharmacy DIR fees increased by 91,500 percent between 2010 and 2019. For context, a $4 gallon of milk increased by that much would cost $3,660. (NCPA).

Page 3 – Lines 5 thru 11

We would agree with changing the definition of pharmacy benefits manager as suggested to reflect the concerns raised by self-funded pools/trust. By making this change, we can avoid or lessen concerns around the entire law being preempted by ERISA and provide clarity for self-funded ERISA plans.

Page 3 – Lines 25-26

Twenty years ago, when this law was passed, the "substitution of one prescription drug for another" was really the only other PBM related law under 19-02.1, Since the passage of that law, the ND Legislative Assembly has passed a number of other PBM reforms and they are placed under 19-02.1. HB 1584 would help bring the rest of the PBM laws in 19-02.1 under enforcement of the Insurance Commissioner.

Page 4 – Lines 3-7

HB 1584 adds two more provisions dealing with PBM contracting practices. In recent years, the PBMs have started to offer "silent agreement" contracts. They basically send out a fax or email and state "if we do not hear from you in the next 14 days, the pharmacy will automatically agree to the terms and conditions." HB 1584 looks to add language that requires a signature from the pharmacy and PBM before a contract is finalized and enforceable.

HB 1584 also looks to provide the ability of a pharmacy to opt-out of a PBM contract giving a 90-day notice. We are seeing PBMs trying to lock pharmacies into multi-year contracts with no

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reasonable opt-out structure. PBMs can drop a pharmacy from the network with little to no notice, so we feel it is fair that pharmacies are given a more reasonable way to opt-out of a PBM contract. Providing a 90-day notice should be a reasonable request.

Page 5 – Last Page – Enforcement and Penalties

This section would hopefully establish not only an enforcement pathway but provide some expertise and help to the insurance commissioner's office. There are a number of states that have placed PBM enforcement with their Insurance Commissioner. Maybe I am wrong, but I assume the ND Insurance Commissioner, Board of Pharmacy and ND Health & Human Services could enter into a meaningful agreement(s) to help ease the workload and help provide additional expertise. Depending on what the agreement(s) looks like, the Board of Pharmacy could help with fielding complaints, fact finding, hearings, etc. and then turn things over to the Insurance Commissioner for final review and potential enforcement. The penalties section is kind of self-explanatory and should help with PBM compliance.

In conclusion, HB 1584 (1) cleans up language from twenty years ago, (2) removes language to help withstand legal scrutiny, (3) adds a couple of PBM reforms to address market changes, (4) provides a pathway for enforcement and (5) helps streamline enforcement efforts while attempting to help provide expertise to the Insurance Commissioner's office.

Thank you for your time and attention today. I am happy to try and answer any questions.

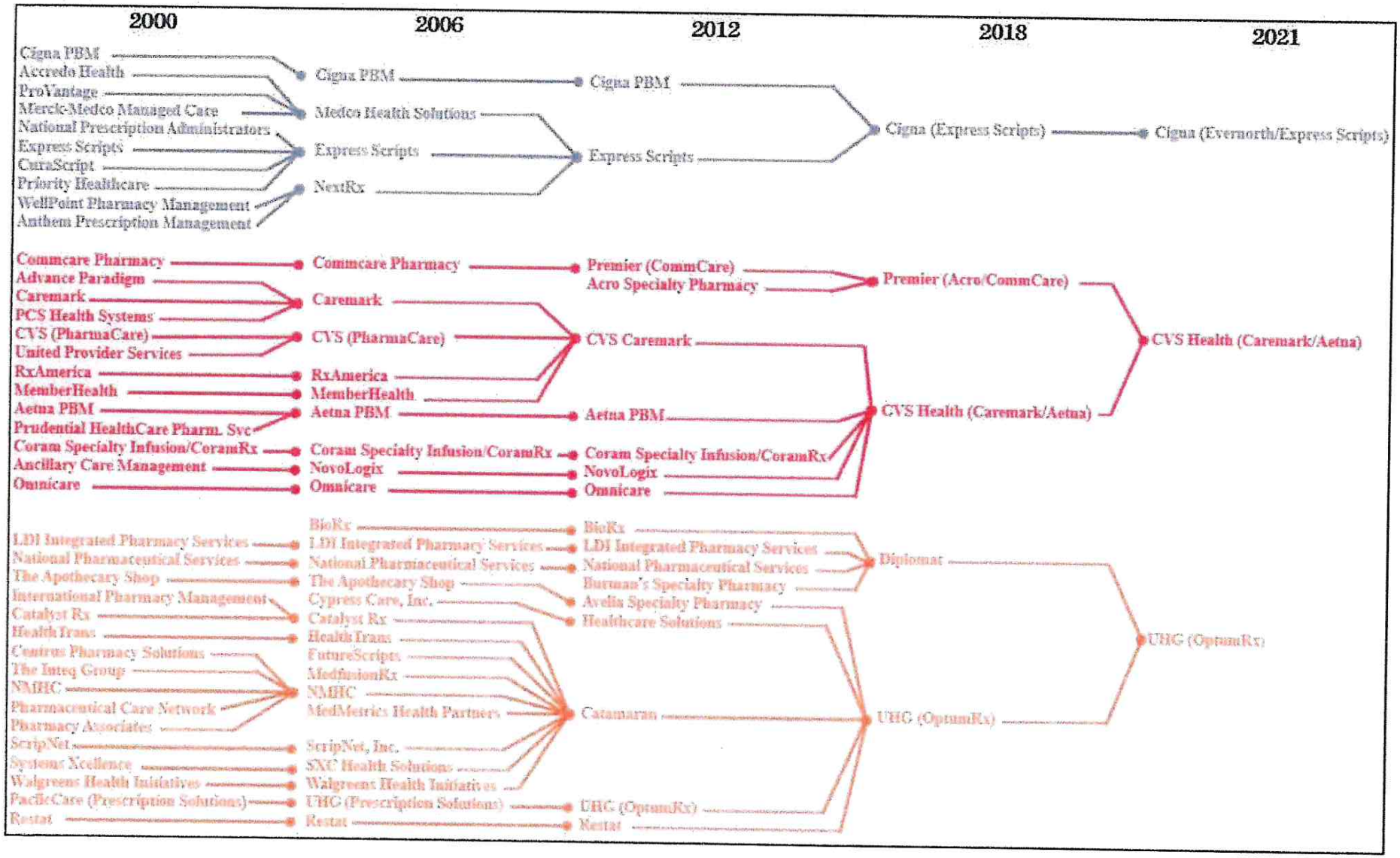
Respectfully Submitted,

Mike Schwab

Mike Schwab

NDPhA - EVP

Figure 3. PBM Parent Entity Consolidation[21]



Alex Kelsch
HB 1584

GROOM LAW GROUP

January 24, 2025

ERISA Preemption of North Dakota House Bill 1584

ERISA preempts any state law that "relates to" an ERISA-covered employee benefit plan. ERISA § 514(a). As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan). A state law "relates to" a plan, and implicates preemption, when it has a "connection with or reference to" an ERISA plan. *Id.* at 147. The Supreme Court has made clear that a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan).

The Supreme Court clarified two main categories of state law that ERISA would preempt: (1) "where a state's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-320 (2016) (internal quotations and citations omitted). Notably, the state law at issue in *Gobeille* applied to the third-party administrator ("TPA") acting on behalf of the ERISA-covered plan. In recognition of the statutory "deemer clause," which prevents states from "deeming" a self-insured, ERISA-covered plan to be an insurer for purposes of the insurance savings clause, the Court held that the Vermont law at issue was preempted, notwithstanding the fact that it applied to the insurer acting as a TPA for the plan. ERISA § 514(b)(2). A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers. *See id.* at 320.

In *Rutledge*, the most recent Supreme Court case analyzing ERISA preemption, the Court affirmed both *Egelhoff* and *Gobeille* when reviewing a state law that regulates the reimbursement amounts PBMs pay pharmacies for drugs covered by prescription drug plans. *Rutledge v. Pharm. Care Mgt. Assn.*, 592 U.S. 80, 86 (2020). In a narrowly tailored decision, the Court held that the state law was not preempted by ERISA because it merely regulated costs rather than dictate ERISA-plan choices. *See id.* at 81. Instead, the Court focused squarely on the facts of the Arkansas cost-regulation while applying earlier Court precedent addressing the extent to which state-level cost regulation is preempted. Importantly, the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and found that the state law did not govern a "central matter of plan administration" by increasing costs for ERISA plans without forcing plans to adopt certain rules for coverage. *Id* at 80; *Gobeille* at 320. Moreover, the Court in *Rutledge* also reaffirmed the long-held view of the Court that a state law "which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans," and are thus subject to preemption. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983); *Rutledge*, 592 U.S. at 86-87.

More recently, the Tenth Circuit properly read *Rutledge* as being limited to indirect cost regulation. In *Mulready* the court examined an Oklahoma state law that imposed regulations on PBMs and pharmacy networks in an effort to establish minimum and uniform guidelines regarding a patient's right to choose a pharmacy provider. *PCMA. v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023). The state law included four key provisions that subjected PBMs to certain rules including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network pharmacies. *See id.* at 1190-1191. The court held that all four provisions were preempted by ERISA because they had an impermissible connection with ERISA plans by mandating certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit). *Id.* at 1199-1200. The court found that the Oklahoma law was an attempt by the State to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration." *Id.* at 1200.[1]

ND House Bill 1584

North Dakota House Bill 1584 ("HB 1584") expands the scope of the state's insurance laws governing pharmacy benefit managers ("PBMs") by removing the current law exclusion of those requirements with respect to services provided to ERISA-covered, self-insured group health plans. As a result, a number of current law and proposed statutory provisions should be preempted by ERISA based on existing Supreme Court jurisprudence, including *Rutledge*. In the following chart, we identify the specific provision, provide a description of the provision, and include the basis for federal law preemption, assuming that the State seeks to impose these requirements with respect to self-insured, ERISA-covered plans.

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
N.D. Cent. Code Ann. § 26.1-27.1-04(2) and 26.1-27.1-04(3) (proposed)	Requires PBMs to accept an pharmacy willing to accept the terms of the PBMs' contracts; requires that PBMs offer opt-in contracts.	This provision limits the ability of ERISA-covered plans to determine the scope of their pharmacy networks, which is inherent in the plan's benefit design. Thus, the provision should be preempted because it requires a specific benefit design choice by the plan sponsor consistent with the holding in *Mulready*.
N.D. Cent. Code Ann. § 19-02.1-02(14) (applied to PBMs through § 26.1-27.1-04(1))	Prohibits a PBM from requiring a different drug or brand of drug to be dispensed in place of the drug or brand of drug ordered or prescribed without the express	This limits the ability of plans to adopt formulary designs that utilize lower cost, therapeutic equivalents. As a result, this provision should be preempted

[1] Notably, the Tenth Circuit also squarely rejected the State's argument that the state law in question was not preempted by ERISA because the law regulates PBMs rather than the actual health plan. *Id.* at 1194. Many courts have recognized that state laws regulating PBMs function as the regulation of an ERISA plan because most plans cannot operate without a PBM. *Id.* at 1195

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
	permission in each case of the person ordering or prescribing.	because it requires a specific benefit design choice by the plan sponsor consistent with the holding in *Mulready*.
N.D. Cent. Code Ann. § 26.1-27.1-05	Proscribes the payment terms that PBMs must offer their clients.	This provision could impose acute *and* direct economic burden on plans because it could limit the ability of plans to enter into high-value contracts Moreover, it could directly conflict with ERISA's fiduciary duty to act solely in the interest of the plan. As a result, the provision addresses a central matter of plan administration and fiduciary obligation, and should be preempted per *Gobeille*.

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1584
2/18/2025

A BILL for an Act to create and enact two new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to provide a penalty; and to declare an emergency.

10:21 a.m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Member Absent: Representative Christy

Discussion Topics:

- Potential funding
- Regulatory fund appropriation
- PBM regulation
- Insurance Department enforcement
- Licensing requirement
- Specific PBM license

Representative Kasper presented amendment language #37977 and # 37978

10:57 a.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

HB 1584 Amendment

Page 3 – Delete Lines 5-11

Replace with new pharmacy benefit manager definition.

"Pharmacy benefit manager" means a person who performs pharmacy benefits management, as a third party, under a contract or other financial arrangement with a covered entity. The term does not include a health benefit plan that manages or directs its own pharmacy benefits.

SECTION XX. TRANSFER - EXEMPTION - FULL-TIME EQUIVALENT POSITION ADJUSTMENTS. Notwithstanding any other provisions of law, the insurance commissioner may increase or decrease authorized full-time equivalent positions as needed, subject to availability of funds, during the biennium beginning July 1, 2025, and ending June 30, 2027. The insurance commissioner shall report to the office of management and budget and legislative council any adjustments made pursuant to this section.

SECTION XX. TRANSFER – DRUG PRICING FUND TO INSURANCE REGULATORY TRUST FUND. The office of management and budget shall transfer any balance in the drug pricing fund on the effective date of this Act to the insurance regulatory trust fund.

SECTION XX. AMENDMENT – Continuing appropriation. Section 26.1-01-07.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-07.1. Insurance regulatory trust fund established.

1. There is hereby created a trust fund designated "insurance regulatory trust fund". The following amounts must be deposited in the insurance regulatory trust fund:

a. All sums received under section 26.1-01-07.

b. All sums received under section 26.1-01-07.2 from the insurance regulatory trust fund investments.

c. All sums received under 26.1-36.10.

d. All retaliatory fees imposed upon persons by the insurance department as authorized by law.

e. All administrative penalties, fines, and fees collected by the commissioner from any person subject to this title.

f. Any other amounts provided by legislative appropriation.

2. The moneys so received and deposited in the insurance regulatory trust fund are reserved for use by the insurance department to defray the expenses of the department in the discharge of its administrative and regulatory powers and duties as prescribed by law and are provided on a continuing appropriation basis. ~~subject to the applicable laws relating to the appropriations of state funds and to the deposit and expenditure of state moneys. The insurance department is responsible for the proper expenditure of these moneys as provided by law.~~

~~3. Except as otherwise provided by law, after the fiscal year has been closed and all expenses relating to the fiscal year have been accounted for, the office of management and budget shall transfer any fund balance remaining in the insurance regulatory trust fund that exceeds one million five hundred thousand dollars to the general fund.~~

SECTION XX. REPEAL. Section 26.1-36.10-07 of the North Dakota Century Code is repealed.

SECTION XX. AMENDMENT. Section 26.1-36.10-06 of the North Dakota Century Code is amended and reacted as follows:

26.1-36.10-06. Rulemaking - Forms - Services – Records - Fees.

1. The commissioner may adopt rules to implement this chapter.

2. In consultation with the board, the commissioner shall develop forms that must be used for reporting required under this chapter.

3. The commissioner may contract for services to implement this chapter.

4. A report received by the commissioner is an exempt record as defined by section 44-04-17.1; however, as provided under section 44-04-18.4 any portion of a report which discloses trade secret, proprietary, commercial, or financial information is confidential if it is of a privileged nature and has not been previously publicly disclosed.

5. The board shall deposit up to six hundred dollars of every wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the insurance regulatory trust fund.

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1584
2/18/2025

A BILL for an Act to create and enact two new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to provide a penalty; and to declare an emergency.

3:12 p.m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Member Absent: Representative Christy

Discussion Topics:

- Insurance FTE's
- Separate license class
- West Virgina language
- Initial and renewal fee
- 1.68 million
- 30 days to opt in
- 90 days' notice to opt out
- PBM fees

3:15 p.m. John Arnold, Deputy Commissioner, ND Insurance Department, submitted amendment language #38008 and #38010.

3:17 Representative Kasper presented additional data, #38004 and #38010.

3:26 p.m. Representative Kasper moved Adopt Amendment in changing the definition of "Pharmacy benefit manager" (2/18/25 AM #37977) and the requested changes from the Insurance Department regarding licensing, fees and application #38008.

3:27 p.m. Representative Schauer seconded the motion.

Voice vote.

Motion passed.

3:27 p.m. Representative Koppelman moved Do Pass as amended.

3:27 p.m. Representative Schatz seconded the motion.

Representatives	Vote
Representative Jonathan Warrey	Y
Representative Mitch Ostlie	AB
Representative Landon Bahl	AB
Representative Collette Brown	Y
Representative Josh Christy	AB
Representative Lisa Finley-DeVille	Y
Representative Karen Grindberg	Y
Representative Jorin Johnson	Y
Representative Jim Kasper	Y
Representative Ben Koppelman	Y
Representative Dan Ruby	Y
Representative Mike Schatz	Y
Representative Austin Schauer	Y
Representative Daniel R. Vollmer	Y

Motion passed 11-0-3.

3:34 p.m. Representative Kasper will carry the bill.

3:34 p.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1584

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

A BILL for an Act to create and enact two new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to provide a penalty; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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~~policies or ~~contract~~contracts that do not include prescription drug coverage.

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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee; pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other fincancial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. 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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 2. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from the the commissioner under to this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefit manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website that includes a request for the following information:

a. The identity, address, and telephone number of the applicant;

b. The name, business address, and telephone number of the contact person for the applicant;

c. If applicable, the federal employer identification number for the applicant; and

d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefit manager to complete the licensure process.

3. The term of licensure is one year from April thirtieth through March thirty-first.

4. The pharmacy benefit manager shall pay an annual renewal fee no later than April thirtieth.

5. The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars. The applicant shall submit the fee with an application for registration. An initial application fee is nonrefundable. The commissioner shall return a renewal application fee if the renewal of registration is not granted.

6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.

7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each applicant and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 3. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.
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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.
3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or entities contracting on behalf of pharmacies.
4. A pharmacy must be allowed to opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 4. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

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

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received from the pharmacy benefits manager has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract with a pharmacy benefits manager and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 5. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~for implementation of this chapter.

SECTION 6. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.
2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities or individuals for losses incurred as a result of the violation.
3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 8. EMERGENCY. This Act is declared to be an emergency measure.

REPORT OF STANDING COMMITTEE
HB 1584

Industry, Business and Labor Committee (Rep. Warrey, Chairman) recommends **AMENDMENTS (25.1281.01001)** and when so amended, recommends **DO PASS** (11 YEAS, 0 NAYS, 3 ABSENT OR EXCUSED AND NOT VOTING). HB 1584 was placed on the Sixth order on the calendar.

Kasper, Jim M.

From: Kasper, Jim M.
Sent: Tuesday, February 18, 2025 2:59 PM
To: Kasper, Jim M.
Subject: BCBS MEMO ON HB 1584--TUESDAY FEB 18, 2025
Attachments: image002.png; image001.png; HB 1584 Info Alert .pdf

BLUE CROSS MEMO BEING CIRCULATED ON HB 1584 TUESDAY FEBRUARY 18, 2025

Representative Jim Kasper
North Dakota House of Representatives
District 46, Fargo
Chairman Government & Veterans Affairs Committee
Chairman Special House Committee on Ethics

Sent: Tuesday, February 18, 2025 8:14 AM

Subject: FW: PLEASE READ : House Bill 1584 - Self Funded PBM oversight by state regulators | BCBSND SF Clients

Just received this from Blue Cross

From: Gregory Poziembo <Gregory.Poziembo@bcbsnd.com>
Sent: Tuesday, February 18, 2025 8:09 AM
Subject: PLEASE READ : House Bill 1584 - Self Funded PBM oversight by state regulators | BCBSND SF Clients

Good Morning

As a Self Funded Client of BCBSND...

I wanted to make you aware of House Bill 1584, which aims to regulate PBMs who serve self-funded health plans in North Dakota by removing the protections given to self-funded ERISA plans from state regulation of their PBMs. I encourage you to review the impact this bill could have on self-funded plans' freedom to choose pharmacy benefits and take action by early next week if you feel it is appropriate.

If you have additional questions, please let me know.

SIMPLIFYING HEALTHCARE
ENSURING AFFORDABILITY
ELEVATING WELL-BEING

Gregory Poziembo (Po-zim-bo)
Strategic Account Manager
Sales Division
BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
701-282-1880 (work) 701-277-2454 (fax)
gregory.poziembo@bcbsnd.com
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House Bill 1584 Information Alert

What it is:

HB 1584 is a bill that aims to regulate Pharmacy Benefit Managers (PBMs) who serve self-funded health plans in North Dakota by removing the protections given to self-funded ERISA plans from state regulation of their PBMs. This legislation will limit design choice and increase state regulation of federally regulated self-funded groups, like yours, which will increase pharmaceutical costs.

Proposed amendments to the definition of a "covered entity" and "pharmacy benefits manager" to remove self-funded plans administering their own pharmacy benefits do nothing to protect self-funded groups, as self-funded groups overwhelmingly rely on PBMs to manage their pharmacy benefits.

What it means:

Your freedom to choose your own pharmacy benefits, including lower cost options, is at risk.

- The North Dakota Insurance Department states that there is not a known benefit to the consumer for this type of legislation, and in other states where legislation like this has passed prescription drug costs did not come down.[1]
- This legislation strips ERISA self-funded health plans of their ability to design pharmacy benefits that helps them manage costs. This legislation could lead to pharmacy network design restrictions, prescription drug coverage mandates or even medical benefit Rx drug coverage with out-of-network providers. These risks could cost self-funded plans an estimated $25 million in year one.[2]
- This legislation will likely result in lengthy legal battles that could be costly for taxpayers.

What you can do:

Self-funded health plans can:

- Reach out to the House Industry, Business and Labor Committee and urge them to preserve the protections in current law for self-funded ERISA plans that HB 1584 seeks to remove. Specifically, the amendments to the definitions of "covered entity" and "pharmacy benefit manager" should maintain the language currently found in state law, which exempts PBMs serving self-funded ERISA plans from state regulation.
- The bill could be taken up by the Committee as soon as Monday morning, so we would encourage you to express your concerns with these representatives.

Chairman Jonathan Warrey	jwarrey@ndlegis.gov
Representative Jorin Johnson	jjohnson@ndlegis.gov
Representative Mitch Ostlie	mostlie@ndlegis.gov
Representative Landon Bahl	lbahl@ndlegis.gov
Representative Collette Brown	cbrown@ndlegis.gov
Representative Josh Christy	jchristy@ndlegis.gov

[1] HIBL-1584-20250211-37127-N-ARNOLD_JOHN_R.pdf

[2] HIBL-1584-20250211-37131-A-KALANEK_WILLIAM.pdf, HIBL-1584-20250211-37129-A-POWER_MICHAEL.pdf

Representative Lisa Finley-Deville	lfinleydeville@ndlegis.gov
Representative Karen Grindberg	kgrindberg@ndlegis.gov
Representative Jim Kasper	jkasper@ndlegis.gov
Representative Ben Koppelman	bkoppelman@ndlegis.gov
Representative Dan Ruby	druby@ndlegis.gov
Representative Mike Schatz	mschatz@ndlegis.gov
Representative Austen Schauer	aschauer@ndlegis.gov
Representative Dan Vollmer	dvollmer@ndlegis.gov

Arnold
1584
2/18/24

Section 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.~~

1. A person may not establish or operate as a pharmacy benefits manager in the state without first obtaining a license from the commissioner pursuant to this section. Any person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefit manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its publicly accessible internet website that includes a request for the following information:

a. The identity, address, and telephone number of the applicant;

b. The name, business address, and telephone number of the contact person for the applicant;

c. When applicable, the federal employer identification number for the applicant; and

d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefit manager to complete the licensure process.

Section 26.1-27.1-02.1 - License Term and Fee

1. The term of licensure shall be one year from April thirtieth through March thirty-first.

2. The pharmacy benefit manager shall pay an annual renewal fee no later than April thirtieth.

3. The commissioner shall determine the amount of the initial application fee and the renewal application fee for the registration. The fee shall be submitted by the applicant with an application for registration. An initial application fee is nonrefundable. A renewal application fee shall be returned if the renewal of the registration is not granted.

4. The amount of the initial application fee is two hundred fifty dollars. The pharmacy benefit manager shall pay an annual fee of one hundred dollars to maintain the license.

5. Each application for a license, and subsequent renewal for a license, shall be accompanied by evidence of financial responsibility in an amount of one million dollars.

Section 26.1-27.1-02.2 - Application

1. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall make a review of each applicant and shall issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner pursuant to this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

2. The license may be in paper or electronic form, is nontransferable, and shall prominently list the expiration date of the license.

Kasper, Jim M.

From: Arnold, John R. <jrarnold@nd.gov>
t: Tuesday, February 18, 2025 1:00 PM
To: Kasper, Jim M.
Cc: Godfread, Jon
Subject: RE: FUND BALANCE IN DRUG TRANSPARENCY FUND--FROM REP. JIM KASPER--TUESDAY FEB 18, 2025

Good afternoon, Rep. Kasper.

Below are the fiscal year end balances for 2023 and 2024, as well as year-to-date for the 2025 fiscal year. Although HB 1584 was passed in 2021, the Board of Pharmacy's license renewal for 2021 had already occurred by August 1, hence three instead of four years of data.

2023 FYE Balance $540,952.72

2024 FYE Balance $1,093,018.99

2025 FYTD Balance $1,623,149.58

Thank you,

JOHN ARNOLD | Deputy Commissioner
North Dakota Insurance Department

n: Kasper, Jim M. <jkasper@ndlegis.gov>
. Tuesday, February 18, 2025 12:24 PM
To: Kasper, Rep. Jim <jkasper@ndlegis.gov>; Arnold, John R. <jrarnold@nd.gov>
Subject: FUND BALANCE IN DRUG TRANSPARENCY FUND--FROM REP. JIM KASPER--TUESDAY FEB 18, 2025

RESENDING JIM KASPER

Hello John:

Can you please email the current balance in the Drug Transparency Fund that the ND Pharmacy Association has been donating around $600,000 I think annually to??

This fund should be available to help fund the new PBM overview entity in HB 1584???

Also, if available, the fund balance year ending the past 4 years.

k you.

Jim

Representative Jim Kasper
North Dakota House of Representatives
District 46, Fargo
Chairman Government & Veterans Affairs Committee
Chairman Special House Committee on Ethics
Member Industry, Business & Labor Committee
Cell Phone: 701-799-9000
State Email: jkasper@ndlegis.gov
Bus. Email: jmkasper@amg-nd.com

2025 SENATE INDUSTRY AND BUSINESS

HB 1584

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

HB 1584
3/31/2025

A bill relating to pharmacy benefits managers; to provide a penalty; and to declare an emergency.

2:46 p.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Vice-Chair Boehm, Senator Klein, Senator Kesel, Senator Enget

Discussion Topics:

- Pharmacy Benefits Managers (PBMs)
- PBM regulation, reform, and transparency
- Market changes and fee increases
- Tax-payer funded lawsuits and legal concerns
- PBM history and magnitude of companies
- Spread pricing definition
- Health care and prescription drug cost increases
- PBMs in other states
- Employment Retirement Income Security Act (ERISA) Plans and exemptions
- Insurance department funding
- Existing PBM laws and enforcement
- Rebate aggregator definition and the rebate model
- Insurance Regulatory Trust Fund
- Drug Pricing Fund and the ND Board of Pharmacy
- Full Time Equivalent employees
- Increase in mandates
- Disclosure and reporting requirements for PBMs
- Pharmacy network requirements
- Expressed reference preemptions
- Addition of dedicated staff and incoming complaint volumes
- Drug Transparency Program

2:47 p.m. Representative Jim Kasper, District 46, testified in favor, introduced the bill, and submitted testimony #44493, #44494, and #44495.

3:01 p.m. Michael Schwab, ND Pharmacists Association, testified in favor and submitted testimony #44474.

3:16 p.m. Don Larson, State Director, National Federation of Independent Businesses, testified in favor and submitted testimony #44417.

3:17 p.m. Arik Spencer, President and CEO, Greater ND Chamber, testified in opposition and submitted testimony #44581.

3:29 p.m. Rick Clayburg, President and CEO, ND Bankers Association, testified in opposition.

3:38 p.m. Megan Hruby, Blue Cross Blue Shield ND, testified in opposition and submitted testimony #44488.

3:47 p.m. Sara Gerving, Associate General Counsel, Blue Cross Blue Shield ND, testified in opposition.

4:02 p.m. Robert Smith, partner, Katten Muchin Rosenman LLP, testified in favor and submitted testimony #44440.

4:14 p.m. Alexander Kelsch, America's Health Insurance Plans (AHIP), testified in opposition submitted testimony #44471 and #44472.

4:20 p.m. Michelle Mack, Pharmaceutical Care Management Association (PCMA), testified in opposition and submitted testimony #44454.

4:26 p.m. John Arnold, Deputy Commissioner, ND Insurance Department, testified in neutral and submitted testimony #44475.

4:45 p.m. Mark Hardy, Executive Director, ND Board of Pharmacy, testified in neutral and submitted testimony #44452.

Additional written testimony:

Katy Johnson, President, American Benefits Council, submitted testimony #44438 in opposition.

Dylan Wheeler, Head of Government Affairs, Sanford Health Plan, submitted testimony #44461 in opposition.

4:47 p.m. Chairman Barta closed the hearing.

Audrey Oswald, Committee Clerk

Senate Industry and Business

03/31/25

Testimony in Support of House Bill 1584

Chairman Barta and Members of the Committee, on behalf of the National Federation of Independent Business (NFIB) and its thousands of small business members, we are here to express strong support for reforming the practices of Pharmacy Benefit Managers (PBMs). Small businesses across the North Dakota, have been facing increasing healthcare costs, particularly prescription drug expenses, which continue to strain their operations and budgets. PBMs, which serve as intermediaries between insurers, pharmacies, and drug manufacturers, have grown increasingly opaque and complex, leading to rising costs for small business owners and their employees. Reforming the PBM industry is necessary to bring transparency, fairness, and cost relief to the marketplace.

PBMs often negotiate rebates and discounts with drug manufacturers, but these agreements are not always passed on to consumers. Instead, the savings are frequently kept by PBMs or passed to health insurers without benefiting the small businesses and their workers who are directly affected by high drug prices. This lack of transparency in PBM pricing structures creates an environment where small business owners and their employees are paying higher prices for prescription medications than they should. Reforms that require PBMs to disclose these rebates, as well as the actual costs they are charging to employers and consumers, would go a long way in addressing these challenges.

Small businesses are the backbone of our economy, and they deserve a healthcare system that is efficient, transparent, and fair. PBMs, in their current

form, are contributing to the financial strain small businesses face in providing healthcare coverage. By supporting PBM reform, this committee has the opportunity to enact meaningful change that will reduce prescription drug costs, promote transparency, and improve healthcare outcomes for small business owners and their employees. We urge you to move forward with reforms that address these critical issues, ensuring that small businesses are not left behind in the ever-evolving healthcare landscape.

Thank you for your time and consideration.

Don Larson
State Director
NFIB

AMERICAN BENEFITS COUNCIL

March 27, 2025

Senator Jeff Barta
Chairman
Senate Industry and Business Committee
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

RE: North Dakota House Bill 1584

Dear Chairman Barta:

The American Benefits Council ("the Council") is writing with respect to North Dakota House Bill 1584, currently under consideration by the Committee on Industry and Business ("the Committee"). While the Council greatly appreciates efforts to reign-in prescription drug costs for employers and participants, we want to bring to your attention that H.B. 1584 includes numerous provisions that present significant issues under the federal Employee Retirement Income Security Act of 1974 (ERISA). **In particular, HB 1584's proposed removal from the North Dakota Century Code of the exclusion for ERISA-covered, self-insured group health plans would be in violation of ERISA's fundamental preemption provision. In doing so, if HB 1584 becomes law, it would unintentionally undermine strategies to control costs; and also result in inconsistent treatment of employees of the same employer, covered under the same plan but working in different states.**

The Council is dedicated to strengthening employer-sponsored benefit plans that provide vitally important health coverage protection to American workers and their families. The Council's members not only include large multi-state employers, but also organizations providing health plan products and support services to employers of all sizes. The Council's membership represents numerous industries employing workers in North Dakota (*e.g.* banks, financial and investment firms, airlines, hotels, insurers, agriculture equipment, energy and petroleum, telecommunications networks, etc.)

1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

Given the importance of employer-sponsored health coverage for so many residents of North Dakota, employers in the state have a significant interest in the extent to which states may regulate self-insured, ERISA-covered plans and the proper interpretation of the law's preemption provision. A more complete explanation of the vital long-standing policy objectives supporting ERISA preemption and how HB 1584 as currently drafted is directly at odds with that policy is provided in the attachment to this letter.

While ERISA preemption enables an employer to provide consistent benefits to its workforce, by no means does it result in a one-size-fits-all approach among all employers. Quite the contrary, it allows employers in North Dakota and elsewhere to design and operate plans in a manner tailored to the unique needs of its workforce.

In light of these circumstances, and as detailed below, the Council believes that if HB 1584 is to be considered at all, unless its definition of "covered entity" is modified so as not to apply to self-insured, ERISA-covered plans the law would violate ERISA's preemption provision.

NORTH DAKOTA HB 1584

HB 1584 expands the scope of the state's insurance laws governing pharmacy benefit managers (PBMs) by removing the exclusion from such requirements for ERISA-covered, self-insured group health plans. The recent amendment to HB 1584 in the House of Representatives to the definition of "pharmacy benefit manager" ***does not, in any way, alter the extent to which ERISA's federal preemption framework prevents application of these state law provisions to self-insured, ERISA-covered group health plans.*** This is true whether the state law applies directly or indirectly (via regulation of the self-funded plan's PBM). The amendment merely clarifies that a plan that administers and manages its own pharmacy benefits is not considered a PBM. Nonetheless, ERISA's preemption provision applies to such a plan.

In particular, HB 1584's imposition of an "any-willing pharmacy" provider requirement on self-insured, ERISA-covered plans specifically regulates employers' benefit design choices and is squarely preempted by ERISA. The most recent federal appeals court to address this exact type of state regulation viewed it as clearly having a "connection with" the underlying ERISA-covered plans and held that the network regulation was preempted. *PCMA. v. Mulready*, 78 F.4th 1183, 1190 (Circuit Court of Appeals 2023). The U.S. Supreme Court has not yet decided whether to review the case.

HB 1584 limits the ability of plans to require the use of lower-cost, therapeutic equivalents. These plan designs are necessary to achieve efficiencies in the current drug

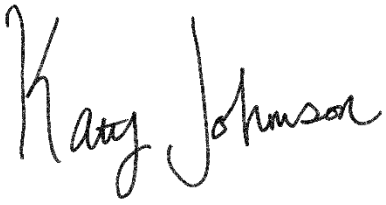
supply chain. State interference in this aspect of plan design clearly binds plans to a given benefit structure. As a result, that provision unquestionably has an impermissible connection with ERISA-covered plans and should be preempted.

The Council has similar concerns with the application of current law requirements to self-insured, ERISA-covered plans caused by HB 1584's deletion of the exception for ERISA plans in the definition of "covered entity." In particular, the Council has strong concerns with the application of the current law regulation of PBM and plan contracts. While the contracting methodology mandated under state law may provide the optimal economic outcome for some employers, other employers may seek different, value-based fee arrangements that are impermissible under the proposed law.

Flexibility is essential for employers to contract prudently with service providers, as mandated by ERISA's fiduciary duties. Requiring state-by-state contracting with plan service providers imposes the significant administrative burdens ERISA's preemption provision was designed to prevent with its focus on uniform plan administration.

The Council appreciates the committee's consideration of our comments. We urge the Committee to ensure that North Dakota legislation fully acknowledges the scope and extent of ERISA preemption. Please let us know if we may answer any questions or provide additional information that might be helpful to the Committee.

Sincerely,



Katy Johnson
President

cc:

kboehm@ndlegis.gov

menget@ndlegis.gov

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jklein@ndlegis.gov

Attachment

AMERICAN BENEFITS COUNCIL

ERISA Preemption is Essential for Maintaining Employer-Sponsored Health Coverage

The federal Employee Retirement Income Security Act of 1974 (ERISA) preemption provision is an essential tool to ensure that multi-state employers are able to continue to offer consistent, affordable and high-value health coverage to workers and their families. It enables uniform plan administration, flexibility in plan benefit design, and the ability to treat employees consistently regardless of where they live or work.

The fundamental policies that underpinned ERISA's preemption provision when the law was enacted 50 years ago remain just as important today — indeed more so — in order to support employees' access to robust employee benefits. That is because ERISA's preemption standard is increasingly vital for mid-size and small employers as the growth in remote work and mobile nature of the workforce has transformed them into "multi-state" employers.

ERISA preemption removes a barrier to mobility of employees within an employer's workforce, facilitating the transfer of talent to other company locations and opportunities nationwide. Additionally, consistency in plan design and operation has brought tremendous value to working families and to the health system itself.

Attempts by states to regulate self-funded employer health benefits — either directly via laws specifically aimed at group health plans or indirectly via laws applicable to the plan's service provider (in the case of HB 1584, pharmacy benefit managers) — are very problematic for employers and their workforces. Such laws hinder the ability of an employer to apply a uniform drug benefit across its employee population and they undermine pharmacy benefit plan design, which employers carefully develop to provide broad, affordable access to prescription drugs.

Under well-established case law outlining the scope and application of ERISA preemption, courts evaluate whether a state law has an impermissible "reference to" or "connection with" the ERISA-covered plan in determining whether a state law is preempted by ERISA. An impermissible reference to an ERISA-covered plan arises where the state law specifically references the ERISA-covered plan or the existence of the ERISA-covered plan is essential for the state law to take effect. An impermissible

connection with an ERISA covered plan arises when the operation of the state law interferes with nationally uniform plan administration, or affects a central matter of plan administration, or imposes burdens on plans that parallel those required under ERISA, or imposes direct and/or acute economic burdens on plans, or binds the employer to a specific benefit design choice.

Several provisions of HB 1584 have obvious, impermissible connections with self-insured, ERISA-covered plans, and invade the regulation of plan administration and/or require plan sponsors to adopt specific benefit designs (*e.g.*, restrictions on pharmacy network design, plan contracting, and covered drug benefits). For these reasons the American Benefits Council urges the Committee to ensure that HB 1584, if it is to be considered, is not applicable either directly or indirectly to ERISA-covered self-funded group health plans.

Testimony of Robert T. Smith,
Partner, Katten Muchin Rosenman LLP, and
Former Special Assistant Attorney General of North Dakota,

Before the Committee on Industry and Business,
North Dakota Senate:

The State's Authority to Regulate Pharmacy Benefit Managers in the Wake of *Rutledge* and *Wehbi*

March 31, 2025

Chairman Barta, thank you for providing me with an opportunity to testify before the Senate Committee on Industry and Business about the State's authority to regulate pharmacy benefit managers following the U.S. Supreme Court's decision in *Rutledge v. PCMA*, 592 U.S. 80 (2020), and the U.S. Court of Appeals for the Eighth Circuit's more recent decision in *PCMA v. Wehbi*, 18 F.4th 956 (8th Cir. 2021). As you know, *Rutledge* and *Wehbi* held that States may regulate PBMs even when those PBMs are serving plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA).

I am a partner at Katten Muchin Rosenman LLP in Washington, D.C., and a former special assistant attorney general for North Dakota, but I am appearing here solely in my individual capacity. Nothing I say here should be attributed to Katten or the Attorney General's Office. I also want to be clear that no one is compensating me for my time testifying here today. Nor did anyone compensate me for my time preparing to testify. I am here today at the invitation of the Chairman.

I have been involved in every major challenge to State PBM legislation for over a decade, including PCMA's challenges in *Gerhart* (852 F.3d 722 (8th Cir. 2017)),

Rutledge, *Wehbi*, and *Mulready* (78 F.4th 1183 (10th Cir. 2023), *pet. for cert. filed*, No. 23-1213 (U.S. filed May 15, 2024)). In some of those cases, I authored briefs on behalf of *amici curiae* defending the States' authority to regulate PBMs from challenges under ERISA and Medicare Part D. And in *Wehbi*, I led this State's successful defense of two North Dakota laws that regulate PBMs from challenges under ERISA. In that capacity, I twice argued in the Eighth Circuit, served as the principal author of the State's briefing at all levels of the federal judiciary, and successfully petitioned the Supreme Court to intervene when the Eighth Circuit reached the wrong result on the first go-round, and then helped the Eighth Circuit reach the right result on remand.

The results of these efforts—by many dedicated men and women in State AG offices across the country—is clear: The States possess robust authority to regulate PBMs even when those PBMs are serving plans subject to regulation under ERISA. You don't have to just take my word for it. The Supreme Court established as much in *Rutledge*, the Eighth Circuit extended those principles in *Wehbi*, and Texas Attorney General Ken Paxton recognized as much in a recent opinion letter about Texas's own efforts to rein in PBM abuses. *See* Tex. Att'y Gen. Op. No. KP-0480 (Feb. 5, 2025), https://www.texasattorneygeneral.gov/sites/default/files/opinionfiles/opinion/2025/kp-0480.pdf.

As I understand it, the Committee is currently considering House Bill No. 1584, which would shift enforcement authority to the Commissioner of Insurance and make certain technical amendments to the definitions for a "covered entity" and a "pharmacy benefits manager."

I've divided my testimony into four parts: First, I will provide a brief overview of PBMs and State efforts to regulate those entities. Second, I discuss ERISA and the State's authority to regulate PBMs even when those PBMs are serving ERISA plans. Third, I will note how other States are handling enforcement authority and why it makes sense to charge the Insurance Commissioner and the Attorney General with authority to regulate PBMs. Finally, I explain why the Legislative Assembly should enact House Bill No. 1584 to make certain technical amendments to the definitions for "covered entity" and "pharmacy benefits manager" contained in the North Dakota Century Code.

1. State Enforcement of PBM Laws

PBMs are powerful intermediaries who sit between patients and health plans. PBMs enter contracts with benefit plans and insurers to provide beneficiaries with access to prescription drugs. PBMs deliver this access by contracting separately with pharmacies to create networks where beneficiaries can fill their prescriptions. To be clear, PBMs are *not* health benefit plans. Rather, PBMs *sell* health benefit plans access to the pharmacy networks that PBMs create.

For many years, PBMs operated with impunity across the country, shielded by the false claim that any attempt by State governments to regulate their actions would yield to preemption by ERISA. PBMs originally were created to facilitate coverage determinations and quickly adjudicate prescription-drug claims at the pharmacy counter. Over time, PBMs developed an outsized role as the key financial middlemen in the prescription drug supply chain by establishing the prices that pharmacies

would be paid, demanding kickbacks or rebates from drug manufacturers in exchange for favorable formulary placement, and building pharmacy networks that determined which pharmacies could even participate in the marketplace.

Through consolidation and aggressive business practices, three PBMs now control over 80% of prescription drug reimbursements in the United States. These three companies have vertically integrated operations that include retail, mail order, and specialty pharmacies in direct competition with the pharmacies for which they establish reimbursement rates. PBMs have aggressively steered high-dollar medications to mail-order specialty pharmacies they themselves own, which has put their own interests above the plans and patients that PBMs purport to serve.

As PBMs have consolidated their grip over the prescription drug marketplace, their anticompetitive business practices have caused more than 7,000 pharmacies to close their doors just since 2019, according to data from a study at the University of Pittsburgh.[1] At the same time, prescription drug costs have skyrocketed even after adjusting for inflation.[2]

Seeking to take action to correct this trend of increasing prescription drug costs and decreased access to community pharmacies, nearly every State has now enacted legislation that regulates PBMs. These laws include requirements that PBMs apply for and maintain a license, regulating the process and amount of PBM-pharmacy

[1] https://apnews.com/article/pharmacy-closure-drugstore-cvs-walgreens-rite-aid-91967f18c0c059415b98fcf67ad0f84e

[2] https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#Nominal%20and%20inflation-adjusted%20per%20capita%20spending%20on%20retail%20prescription%20drugs,%201960-2021

reimbursements, the composition and quality of the pharmacy networks that PBMs create to sell access to insurers and benefit plans, and conflict of interests and predatory practices that PBMs impose on pharmacies.

2. ERISA and State Laws Regulating PBMs

For many years, there was substantial uncertainty about whether States could regulate third-party service providers, like PBMs, when they were serving plans subject to regulation by ERISA. A federal statute, ERISA regulates private employer- and union-sponsored welfare benefit plans, including prescription drug plans. In one early case, the U.S. Court of Appeals for the Fifth Circuit, which includes Texas, Louisiana, and Mississippi, held that ERISA preempts State insurance laws because they might have a tangential effect on ERISA plans. *See Texas Pharm. Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997). As a result, many States decided to regulate PBMs only when they were serving non-ERISA plans.

The Supreme Court's decision in *Rutledge v. PCMA*, 592 U.S. 80 (2020), rejected the logic that underpins those earlier decisions. In *Rutledge*, the Supreme Court considered a challenge to an Arkansas law that regulates PBMs. Act 900, as Arkansas's law is known, regulates the amounts PBMs reimburse pharmacies for generic drugs; requires PBMs to provide a reasonable administrative appeal procedure, and to update and disclose their reimbursement lists to pharmacies; and allows pharmacies to decline to dispense drugs to beneficiaries when a PBM intends to reimburse the pharmacy less than the pharmacy's cost to acquire the drug. Ark. Code Ann. § 17-92-507. PCMA, a trade association representing the eleven largest

PBMs, claimed that ERISA preempts Act 900. A unanimous Supreme Court disagreed.

According to the Supreme Court, ERISA preempts State laws that have a "connection with" or "reference to" ERISA plans. *Rutledge*, 592 U.S. at 86. A State law has a "connection with" ERISA plans when it "governs a central matter of plan administration or interferes with national uniform plan administration." *Id.* at 87. A State law has a "reference to" ERISA plans if and only if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Id.* at 88.

The Supreme Court held that Act 900 did not have a forbidden "connection with" ERISA plans. *Id.* at 87-88. In so holding, the Court emphasized that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan." *Id.* at 87. Rather, ERISA is "primarily concerned with preempting [State] laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status." *Id.* at 86-87. Thus, the Supreme Court has deemed preempted State laws that dictate eligibility or benefits contrary to the terms of an ERISA plan. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (eligibility); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (benefits); *accord Rutledge*, 592 U.S. at 87. Act 900 does none of these things. The Court explained that the main part of Arkansas's law was a form of "cost regulation," which does not force ERISA plans "to adopt any particular

scheme of substantive coverage." *Id.* at 88. Similarly, the Court held the law's "enforcement mechanisms"—the appeal, update, and decline-to-dispense provisions—simply regulate the relationship between PBMs and third parties that sell access to the "medical benefit[s]" that plans ultimately provide to their beneficiaries. *Id.* at 89-90. The Court emphasized that State law has traditionally governed the relationship between plans and third parties who happen to sell goods and services to ERISA plans. *See id.*

The Court also held that Act 900 did not make a prohibited "reference to" ERISA plans. *Id.* at 88-89. "Act 900 does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan." *Id.* at 88. And "ERISA plans are likewise not essential to Act 900's operation," because "Act 900 regulates PBMs whether or not the plans they service fall within ERISA's coverage." *Id.* at 89.

To summarize, *Rutledge* clarifies that States may regulate PBMs even when PMBs are serving ERISA plans, and ERISA preemption is concerned primarily with State laws only when they "requir[e] payment of specific benefits" or "bind[] plan administrators to specific rules for determining beneficiary status.'" *Id.* at 87. Typical State laws regulating PBMs do neither of these things.

In *PCMA v. Wehbi*, the Eighth Circuit extended the reasoning of *Rutledge* to apply to two North Dakota laws that regulated the accreditation standards that PBMs impose upon pharmacies, a PBM's ability to refer patients to PBM-affiliated pharmacies, and other aspects of how PBMs design the pharmacy networks to which

they charge health plans for access. 18 F.4th 956 (8th Cir. 2021). In that case, PCMA argued the laws impermissibly regulated "benefit design" by limiting the range of choices plans can make in their interactions with PBMs and pharmacies. PCMA Replacement Br. 22-27, 31, *PCMA v. Wehbi*, No. 18-2926 (8th Cir. May 11, 2021), 2021 WL 2022000. But the Eighth Circuit held that ERISA does not preempt these PBM-network provisions, emphasizing that they "do not 'requir[e] payment of specific benefits' or 'bind[] plan administrators to specific rules for determining beneficiary status.'" *Wehbi*, 18 F.4th at 968 (quoting *Rutledge*, 592 U.S. at 87).[3]

3. The Appropriate Entity to Enforce State PBM Laws

As a general matter, most States have charged their insurance commissioner or attorney general (or both) with authority to regulate PBMs. For example, Texas, Arkansas, Louisiana, and Tennessee have all regulated PBMs within their insurance codes and given far-reaching authority to their insurance commissioners. *See, e.g.*, Tex. Ins. Code §§ 1369.551–.555, §§ 1369.601–.610; Ark. Code § 23-92-505; La. Rev. Stat. § 22:1657; Okla. Stat. §§ 36-6958 – 36-6968; Tenn. Code Ann. § 56-7-3113.

North Dakota is somewhat unique in giving six different agencies or executive officials a role in regulating PBMs: the Attorney General, the Board of Pharmacy, the Department of Health and Human Services, the Insurance Commissioner, the Public Employees Retirement Board, and the State's Attorneys.

[3] To be clear, even where ERISA preempts a State law, that law is preempted "only insofar as [it] relate[s] to plans covered by ERISA." *Shaw*, 463 U.S. at 97 n.17. That means that ERISA does not preempt State laws as applied to non-ERISA plans, including government-sponsored plans.

In my opinion, the State might benefit from consolidating most of its enforcement powers with the Insurance Commissioner and the Attorney General. A few thoughts inform this opinion.

Although PBMs are not risk-bearing entities, the three largest PBMs are vertically integrated with large health insurance companies that do bear risk and are subject to traditional regulation by the insurance commissioner. When viewed in the appropriate context, PBMs are simply an extension of how many health insurers ultimately administer fully insured pharmacy benefits. And even when a PBM is acting as a third-party administrator on behalf of a self-insured plan, a PBM is providing the same services that it provides to fully insured plans. The insurance commissioner is best positioned to understand and regulate the plan- and beneficiary-facing sides of a PBM's business.

In addition, ERISA provides the States with more authority to regulate PBMs when the State is regulating insurance. Under ERISA's insurance savings clause, even when a State law makes an impermissible connection with ERISA plans, nothing in ERISA shall be "construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). At the same time, under the so-called deemer clause, an ERISA plan "shall not be deemed to be an insurance company" subject to "any law of any State purporting to regulate insurance companies." *Id.* § 1144(b)(2)(A). According to the United States government, the net effect of these two provisions is to allow States to regulate PBMs under their insurance codes even when those PBMs are providing services to ERISA plans, but a

State cannot regulate ERISA plans directly. *See* Br. of United States as *Amicus Curiae* 17-20, *PCMA v. Mulready*, No. 22-6074 (10th Cir.) (filed Apr. 10, 2023), *available at* 2023 WL 2990378.

According to the Supreme Court, a State law need only be directed towards the insurance industry and affect the risk-pooling arrangement between an insurer and its insured to qualify under the savings clause. *Miller v. Ky. Ass'n of Health Plans, Inc.*, 538 U.S. 329, 334, 338 (2003). As a result, regulating PBMs under the insurance code does two things: It matches the reality that PBMs are often integrated with insurers and regulations of PBMs often affects the risk pooling arrangements of the insurance that is offered, and it further insulates State laws from claims of ERISA preemption.

All that said, there are still benefits to providing the Attorney General with some authority over PBMs. Among other things, PBMs enter business transactions with pharmacies, pharmaceutical manufacturers, other businesses, and governments. As a result, there also is a role for the Attorney General in ensuring that PBMs do not engage in abusive business practices with these entities.

4. The Need for Technical Amendments

As I understand it, the proposed legislation before this Committee, House Bill No. 1584, would make technical amendments to the definitions for "covered entity" and "pharmacy benefit manager." Among other things, the legislation would strike exemptions from these definitions for self-funded plans subject to regulation under ERISA. The Legislative Assembly is right to pursue these changes.

Unfortunately and somewhat counter-intuitively, the Eighth Circuit has twice held that where a State law includes an express exemption for self-funded plans, ERISA will preempt that State law in all of its applications—even as applied to fully insured ERISA plans—because such a provision bears an express reference to ERISA. *See Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 154 F.3d 812, 822-26 (8th Cir. 1998); *see also PCMA v. Gerhart*, 852 F.3d 722, 728-29 (8th Cir. 2017), *abrogated on other grounds by Rutledge v. PCMA*, 592 U.S. 80 (2020). Although the Supreme Court has since rejected other aspects of the Eighth Circuit's ERISA jurisprudence, it has not reviewed the Eighth Circuit's express-reference holding in *Prudential* or *Gerhart*.

As a result, there is a substantial risk that the Eighth Circuit would strike down North Dakota's PBM laws in their entirety as applied to ERISA plans if North Dakota continues to exempt self-funded plans subject to regulation under ERISA. It is therefore critical that the legislature remove the express reference to self-funded ERISA plans from the North Dakota Century Code.

That said, I understand that the Insurance Commissioner has expressed some uneasiness about regulating self-funded ERISA plans directly to the extent that they are self-administering their own pharmacy benefits. Some of this uneasiness may be traced back to an early view of the scope of ERISA preemption—a view that the Supreme Court has since refuted.

Nevertheless, there is an easy solution for this concern. House Bill No. 1584 would modify the definition of "pharmacy benefit manager" to clarify that it applies

only to persons or entities that perform pharmacy benefit management, as a third party, under a contract or other financial arrangement with a covered entity. Doing so would address the Commissioner's apparent concern about regulating self-funded plans that administer their own pharmacy benefits while avoiding the Eighth Circuit's line of decisions that prohibits States from including an express exemption for self-funded ERISA plans.

In addition, changing the definition as House Bill No. 1584 does could further insulate North Dakota's laws from legal challenge. Although the Eighth Circuit has held that the regulation of a PBM is effectively the regulation of an ERISA plan when a PBM is serving an ERISA plan, *see Wehbi*, 18 F.4th at 966-67, the Supreme Court has not blessed this approach—and there are reasons to believe the Supreme Court might decline to do so. In *Rutledge*, for example, the Supreme Court explained that State law governs a plan's relationship with third-party service providers, and PBMs should not be viewed as an exception to this rule. 592 U.S. at 90-91. Similarly, in *Metropolitan Life Insurance Co. v. Massachusetts*, the Supreme Court clarified that that "laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans" under ERISA and are therefore not preempted by that law. 471 U.S. 724, 741 (1985). Because an insurer is a third party that sells a service to ERISA plans, it is possible to view this language to extend to laws that regulate only PBMs. Moreover, the Trump Administration previously supported this distinction in *Rutledge*, explaining that Arkansas's law did not trigger concerns under ERISA because it "regulates PBM administration, not ERISA plan administration."

Br. of United States as *Amicus Curiae* 15, *Rutledge v. PCMA*, No. 18-540 (U.S. Dec. 4, 2019), *available at* 2019 WL 6609430.

* * * * *

In the wake of *Rutledge*, there is growing consensus that States should exercise their authority to regulate PBMs—regardless of the type of plan that the PBM is serving. Even before the Supreme Court decided *Rutledge*, the federal government, forty-six States, and the District of Columbia filed briefs with the Supreme Court arguing that States have robust authority to regulate PBMs.

As a result, there has been a recent surge of State-level regulation of PBMs, and the push for such regulation has straddled the political divide. Red States and Blue States—from Arkansas to California, and everywhere in between—have enacted or are considering legislation to further regulate PBMs. North Dakota should continue to lead the charge by enacting House Bill No. 1584 to make common-sense tweaks to its existing law.

I am happy to answer any of the Committee's questions.

STATE OF NORTH DAKOTA
GOVERNOR KELLY ARMSTRONG

NORTH DAKOTA STATE BOARD OF PHARMACY
OFFICE OF THE EXECUTIVE DIRECTOR

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House Bill 1584 -Pharmacy Benefits Manager Licensure

Senate Industry and Business Committee- Fort Union Room
2:30 P.M. - Monday – March 31st, 2025

Chairman Barta, members of the Senate Industry and Business Committee, for the record I am Mark J. Hardy, PharmD, Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today about House Bill 1584.

The Board of Pharmacy members have long been concerned on the practices of **P**harmacy **B**enefit **M**anagers [PBM] and many patient care issues created by the market powers of PBMs. We continue to hear from patients and pharmacies with concerns of PBM models impacting delivery of care. Our office has watched the growing number of states that enacted meaningful regulatory approaches on PBMs to enforce laws to address market concerns which PBMs influence.

North Dakota was an early adopter of the certification/licensure of PBMs through the Insurance Commissions Office. Laws and court rulings on PBMs have impacted the provisions listed in the original law, which we understand is leading to HB 1584. The state should strongly consider strengthening the regulatory mechanism to enforce those provisions over PBMs to protect the patients in our state.

Our office certainly will be happy to be a partner to the Insurance Commissioner's Office in any capacity if these changes are enacted. I will be happy to answer any questions you may have and do appreciate your time.

Senate Industry and Business Committee
HB 1584
March 31, 2025 - 2:30 pm

PCMA Testimony in Opposition to HB 1584

GOOD AFTERNOON CHAIRMAN BARTA, VICE CHAIRMAN BOEHM AND COMMITTEE MEMBERS:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association, also referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 289 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

At this time, PCMA appreciates the opportunity to provide comments on HB 1584 and respectfully opposes it. This bill, as amended in the House, changes existing law by making changes to definitions, adding to the list of pharmacy benefit manager prohibited practices, and adds enforcement and penalties for noncompliance.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

In 2020, the cost of health care spending per North Dakota resident was $13,204, which ranks it as the 15th highest in the country[1]. Health care costs are already high in North Dakota, and enacting HB 1584 will only exacerbate the problem.

The proposed legislation will change existing North Dakota law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity." The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates, leading to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for their employees. **Please note that the amendment that was adopted in the House, was suggested it "fixed" these issues. However, that is not the case** and in its current form, the language in HB 1584 may apply any existing and future state anti-payor laws to health plans organized under federal ERISA law. This could cost self-funded health plans in the State of North Dakota **$25 million in excess drug spending in the first year alone and $417 million over the next 10 years**.

It should be noted, the U.S. Supreme Court's 2020 decision in the *Rutledge* case was clear and followed 50 years of federal preemption jurisprudence. States may only regulate

[1] USA Facts. "Health in North Dakota." 2023.

self-funded health plans organized under federal ERISA law in very narrow circumstances.

In 2021, the U.S. Court of Appeals for the 8th Circuit ruled via the *Wehbi* case that certain North Dakota anti-PBM laws may be applied to ERISA plans. However, it should be noted that **a state would not be compelled to regulate said plans**. PCMA believes the *Wehbi* decision was wrongly decided, and may embolden bad public policy, including anti-business laws.

PCMA also has concerns with the additional language added under the definition of "Payment received by the pharmacy benefits manager". For example, "pharmacy price concessions" was added, however, pharmacies do not pay PBMs pharmacy price concessions.

In Section 3, under "Prohibited practices", we also have concerns with the added language dealing with opt-in contracts. There are times in the renewal process when getting a signed contract back from a pharmacy in a timely manner is an issue. This could put both patient access and network adequacy at risk.

In Section 6, dealing with "Enforcement", the new language would allow 'collaboration' with the state board of pharmacy. There is a great need to ensure the protection of competitive and proprietary financial information. Therefore, we are **very concerned** about data and information being shared with the board of pharmacy. It should be noted that the Federal Trade Commission (FTC) has opposed regulatory boards composed of market participants in other industries. There is also a US Supreme Court case in *North Carolina State Board of Dental Examiners v. Federal Trade Commission,* that looked into the question and ruled in favor of the FTC. The Board of Pharmacy is comprised of active market participants whose access to market sensitive data could result in a conflict of interest and undermine competition in the prescription drug marketplace.

Finally, in Section 7, dealing with "Administrative penalties" the monetary and civil penalties are extremely excessive, and the language pertaining to restitution to individuals is puzzling given PBMs do not have direct contracts with individuals/members.

It is for these reasons we are opposed to HB 1584 and we recommend a "do not pass" recommendation.

Thank you for your time and consideration. I would be happy to answer any questions.

North Dakota HB 1584 to Cost the State $417 Million In Increased Prescription Drug Costs

In 2020, health care spending cost $13,204 per North Dakota resident, ranking it the 15th highest-spending state on healthcare.[1] In that same time, North Dakota spent over $289 million on retail prescription drugs in the commercial market.[2] Health care costs are already high in North Dakota, and HB 1584 would only contribute to the problem. The proposed legislation would change existing North Dakota law by **removing the exclusion** of self-funded health plans organized under the federal Employee Retirement Income Security Act (ERISA) law from the definition of "covered entity." The result of removing the exclusion of ERISA self-funded health plans would open the door to additional government mandates, leading to increased costs for businesses and other employer groups in North Dakota that choose to self-fund health benefits for employees. The legislation could mean the current anti-business laws would now apply to the self-funded market.

The core mission of pharmacy benefit managers (PBMs) is to reduce prescription drug costs for health plan sponsors so that consumers have affordable access to needed prescription drugs. PBMs offer a variety of services to their health plan sponsor clients and patients that improve prescription adherence, reduce medication errors and manage drug costs.

Current North Dakota law includes provisions to restrict the use of core PBM tools, including preferred pharmacy networks, utilization management tools, and white bagging. Although some of the provisions are subject to interpretation, expanding just the provisions discussed below to self-funded health plans could cost the State of North Dakota **$23 million in excess drug spending** in the first year alone and **$417 million** over the next 10 years.

Projected 10-Year Increases in Prescription Drug Spending in North Dakota, 2025–2034 (millions)

	Self-Insured Group Market
Restrict Pharmacy Networks	$196
Restrict Utilization Management Tools	$97
Restrict White Bagging	$125
Maximum Costs – Three Provisions	**$417**

Methodology: The methodology used to create these cost projections for adopting AWP and utilization management tools was that used by Visante in the January 2023 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools." The methodology used to create the white bagging cost projections is described in "Appendix: White Bagging Dispensing."

[1] USA Facts. "Health in North Dakota." 2023.

[2] PCMA acquired IQVIA data. The statements, findings, conclusions, views, and opinions contained and expressed in this report are based in part on data obtained under license from the following IQVIA Institute information service: IQVIA PayerTrak data for PCMA, 2022, IQVIA Inc. All Rights Reserved.

PCMA

Bill Provisions Descriptions

Expanded restrictions could limit the use of preferred pharmacy networks, specialty pharmacies, and mail-order pharmacies.

- PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Pharmacies that agree to participate in such arrangements are designated as 'preferred' and become members of a preferred pharmacy network. These types of networks have gained traction among plan sponsors and deliver tangible savings for patients.
- Nearly 80% of employers believe that mail-order specialty pharmacies are the lowest-cost site of service compared with retail community pharmacies and other options.[3] The bill guts the ability for health plans and PBMs to create preferred pharmacy networks for plans by mandating an "any willing provider"(AWP) requirement. According to the Federal Trade Commission[4] and academic analysis,[5,6,7] this type of mandate leads to less competition and higher prices for consumers.
- When applied to specialty pharmacies, the consequences of AWP legislation are even greater. Because specialty drugs are dispensed in such low volumes and target rare conditions, it is infeasible for most retail drugstores to stock these medications and provide the specialized services patients require. States do not legally differentiate specialty pharmacies from traditional pharmacies. These payer-aligned specialty pharmacies must meet payers' terms and conditions to be included in preferred pharmacy networks. Of the roughly 64,000 pharmacies in the U.S., only about 400—less than 1%—are accredited as specialty pharmacies by the independent Utilization Review Accreditation Commission.[8]

Expanded restrictions could limit PBM utilization management tools.

- Utilization management tools like prior authorization and step therapy are widely used by PBM clients to help ensure appropriate and cost-effective use of high-cost drugs. Studies have demonstrated that prior authorization can generate savings of up to 50% for targeted drugs or drug categories.[9] Step therapy has demonstrated savings of more than 10% in targeted categories. These tools are becoming increasingly important in managing the rapidly growing use of high-cost specialty pharmaceuticals. Restricting the use of these tools would raise drug benefit costs for both patients and plan sponsors.

Expanded restrictions could expand the ban on white bagging.

- Under a white bagging model, a specialty pharmacy ships the drug for a given patient directly to the health care provider rather than the provider buying the drug and billing the insurer. The cost of these drugs through specialty pharmacies is lower than through the traditional "buy-and-bill" model.
- Legislation that would bar health insurers from implementing white bagging will seriously undermine the ability of health plans and PBMs to manage their medical specialty pharmacy expenditures, and as a result, drug spending in North Dakota would soar. The use of white bagging has real benefits for patients, providers, and health plan sponsors.

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[3] PBMI. "Trends in Specialty Drug Benefits". 2018.
[4] FTC letter to CMS. "Contract year 2015 policy and technical changes to the Medicare advantage and the Medicare prescription drug benefit programs." Mar. 7, 2014.
[5] Klick, Jonathan and Wright, Joshua D., "The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures." Am. L. & Econ. Rev. 192 (2015).
[6] Atlantic Economic Journal. Durrance, C., "The impact of pharmacy-specific any-willing-provider legislation on prescription drug expenditures." 2009.
[7] DHS. Reforming America's Healthcare System Through Choice and Competition. 2018.
[8] URAC. "2022 Specialty Pharmacy Performance Measurement." 2023.
[9] Prime Therapeutics. "Specialty Utilization Management Proves Effective: Ampyra Prior Authorization Improves Safety and Saves Money." 2011.

SANFORD HEALTH PLAN

Chairman Barta and Members of the Senate Industry and Business Committee -

Good Afternoon – my name is Dylan Wheeler, and I serve as Head of Government Affairs for Sanford Health Plan – speaking today in opposition to HB1584. We would request a Do Not Pass recommendation on HB1584.

While on its face, HB1584 suggests that it is limited in scope to pharmacy benefit managers – it is – in fact – much broader in application and in impact to North Dakota. This includes families, businesses, and individuals who obtain their health insurance coverage through a self-funded health plan with the employer. As we know, a large portion of these populations do receive coverage through their employer. HB1584 eliminates and directly rescinds reference to ERISA pre-emption from the term "covered entity" in North Dakota Century Code. This will have the effect of the North Dakota Insurance Department regulating self-funded health plans that administer benefits through PBMs.

Self-funded employer groups rely on PBMs to administer, negotiate, and adapt to the precise benefit design that the employer group is requesting. To put it another way – self-funded groups maintain a certain amount of statutory and regulatory flexibility. Why is this? This is because, in a self-funded health plan arrangement, the employer group takes on the financial risk of paying out claims. Whereas, in a fully-insured arrangement, the insurer takes on the financial risk. This is notable and needs to be understood. Because self-funded groups take on the financial risk, they are mostly exempt from state regulation. Here, with HB1584 – proponents are seeking to encroach on that space, take away business choice, and bring a whole new level of red tape to North Dakota.

ERISA pre-emption and self-funded regulation is a diverse and complex topic, requiring an in-depth analysis of applicable law, litigation, and understanding of state impact. To be clear in our comments, Sanford Health Plan is not suggesting that everything that PBMs do is perfect and should not be scrutinized. Rather, Sanford Health Plan opposes HB1584 because it would take away self-funded clients' ability to innovate unique pharmacy benefit plan designs, impose additional red tape on businesses, and may lead to increased costs on North Dakota consumers. Additionally, HB1584 may lead to litigation as the underlying subject has not been directly addressed by the Courts. There has been some precedent on ERISA pre-emption regarding pharmacy benefits, but the broad scope of HB1584 has not been tested.

As this committee has done with several bills this session, we ask that the committee carefully consider the implications to the business community, existing PBM regulations, and what the long-term effects of HB1584 would have in North Dakota.

I appreciate the opportunity to submit comments and please let me know if you have any questions.

Respectfully,

Dylan C. Wheeler, JD MPA
Head of Government Affairs
Sanford Health Plan

House Bill 1584
North Dakota Senate Industry and Business Committee
March 31, 2025
AHIP Testimony

Thank you for the opportunity to speak before you today. My name is Alex Kelsch, and I am testifying on behalf of America's Health Insurance Plans (AHIP). [1]

AHIP appreciates the opportunity to comment on HB 1584. AHIP is opposed to HB 1584 because we are concerned several provisions in HB 1584, due to the definitional change of "covered entity," are preempted by ERISA.

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to incentivize employers to offer robust coverage to employees across the country, which is the leading source of affordable, comprehensive, and high-quality health coverage in the U.S.

As an exhibit to this testimony, AHIP has provided a legal analysis by the Groom Law Group to the committee supporting this position, which includes a discussion of the ERISA and its legal landscape, a description of the specific provisions included in HB 1584 that conflict with it, and the basis for federal preemption.

AHIP strongly opposes any attempt to regulate ERISA self-funded plans beyond the limits allowed under federal preemption law. Should the proposed policies be enacted, this bill could jeopardize the cost-saving, uniform standards North Dakota's self-insured ERISA employers rely on to provide affordable health insurance coverage to their employees.

A key feature of ERISA is that it established uniform standards that apply to all employees and their beneficiaries – including those residing in different states. These uniform standards enable health plans and employers to provide affordable, consistent and equitable coverage to all of their employees and their dependents.

Today, more than half of Americans receive their health insurance through employer coverage that is governed by ERISA, which affords employers consistency and uniformity of health plan administration. This encourages health care coverage that improves the health and financial stability of employees and their families. In North Dakota, nearly 500,000 residents (65% of the state's population) are covered by employer insurance. Of those North Dakota employers that provide coverage to their employees, 57% of those employers offer self-insured ERISA plans to roughly 282,000 North Dakotans.[2]

AHIP supports a single, cost-saving national standard of regulation for employer-provided health care coverage – one that gives employers the option to assume financial risk

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.
[2] https://www.ahip.org/documents/2023-AHIP_StateDataBook-ND.pdf

and allows employers to choose specifically tailored and uniform benefits for their employees regardless of where they live. This ensures more affordable coverage that is easier to administer and understand.

The alternative proposed by this bill is a slippery slope that could pave the way for a 50-state patchwork of complicated and inconsistent mandates for employer provided coverage. Imposing varied state-by-state mandates could lead to:

- Increased costs for North Dakota employers;
- Increased costs for employees, families and consumers;
- A more complicated health insurance system;
- More red tape and bureaucracy in the health care system;
- Inequal access to care as employees in different states would have different “tiers” of health insurance coverage.

Thank you for your consideration of our concerns. To protect North Dakota employers from these results and increased health care costs**,** AHIP urges you to not to pass HB 1584.

GROOM LAW GROUP

February 25, 2025

ERISA Preemption of North Dakota House Bill 1584

ERISA preempts any state law that "relates to" an ERISA-covered employee benefit plan. ERISA § 514(a). As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan). A state law "relates to" a plan, and implicates preemption, when it has a "connection with or reference to" an ERISA plan. *Id*. at 147. The Supreme Court has made clear that a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff,* 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan).

The Supreme Court clarified two main categories of state law that ERISA would preempt: (1) "where a state's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration." *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312, 319-320 (2016) (internal quotations and citations omitted). Notably, the state law at issue in *Gobeille* applied to the third-party administrator ("TPA") acting on behalf of the ERISA-covered plan. In recognition of the statutory "deemer clause," which prevents states from "deeming" a self-insured, ERISA-covered plan to be an insurer for purposes of the insurance savings clause, the Court held that the Vermont law at issue was preempted, notwithstanding the fact that it applied to the insurer acting as a TPA for the plan. ERISA § 514(b)(2). A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers. *See id*. at 320.

In *Rutledge,* the most recent Supreme Court case analyzing ERISA preemption, the Court affirmed both *Egelhoff* and *Gobeille* when reviewing a state law that regulates the reimbursement amounts PBMs pay pharmacies for drugs covered by prescription drug plans. *Rutledge v. Pharm. Care Mgt. Assn.*, 592 U.S. 80, 86 (2020). In a narrowly tailored decision, the Court held that the state law was not preempted by ERISA because it merely regulated costs rather than dictate ERISA-plan choices. *See id.* at 81. Instead, the Court focused squarely on the facts of the Arkansas cost-regulation while applying earlier Court precedent addressing the extent to which state-level cost regulation is preempted. Importantly, the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and found that the state law did not govern a "central matter of plan administration" by increasing costs for ERISA plans without forcing plans to adopt certain rules for coverage. *Id* at 80; *Gobeille* at 320. Moreover, the Court in *Rutledge* also reaffirmed the long-held view of the Court that a state law "which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans," and are thus subject to preemption. *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 97 (1983); *Rutledge*, 592 U.S. at 86-87.

More recently, the Tenth Circuit properly read *Rutledge* as being limited to indirect cost regulation. In *Mulready* the court examined an Oklahoma state law that imposed regulations on PBMs and pharmacy networks in an effort to establish minimum and uniform guidelines regarding a patient's right to choose a pharmacy provider. *PCMA. v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023). The state law included four key provisions that subjected PBMs to certain rules including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network pharmacies. *See id.* at 1190-1191. The court held that all four provisions were preempted by ERISA because they had an impermissible connection with ERISA plans by mandating certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit). *Id.* at 1199-1200. The court found that the Oklahoma law was an attempt by the State to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration." *Id.* at 1200.[1]

The *Mulready* decision contrasts directly with the view taken by the Eighth Circuit in *Pharm. Care Mgmt. Ass'n v. Wehbi*, where that court evaluated whether ERISA preempted a North Dakota statute prohibiting PBMs from precluding pharmacies in probationary status from their pharmacy networks. *Pharm. Care Mgmt. Ass'n v. Wehbi*, 18 F.4th 956 (8th Cir. 2021). The *Wehbi* court found that such provisions were not preempted by ERISA because the state law merely regulated a "noncentral 'matter of plan administration' with de minimis economic effects" and otherwise did not "'requir[e] payment of specific benefits' or 'bind[ ] plan administrators to specific rules for determining beneficiary status.'" *Id.* at 968 (citations omitted). However, the *Mulready* court has since appropriately explained how this "formulaic" explanation fails to appropriately apply longstanding ERISA preemption standards, which instead require a court to "assess [a state's] law's effects on the structure of the provider network and connected effect on plan design." *Mulready*, 78 F.4th at 1203. The end result is that while *Wehbi* may for the time being remain the controlling law in the Eighth Circuit, the law is anything but settled, as the precise questions presented in *Mulready* and *Wehbi* (regarding network admission) are currently before the United States Supreme Court. *Mulready v. Pharm. Care Mgmt. Ass'n*, 145 S. Ct. 131 (2024) (inviting the views of the Solicitor General).

ND House Bill 1584

North Dakota House Bill 1584 ("HB 1584"), as amended, expands the scope of the state's insurance laws governing pharmacy benefit managers ("PBMs") by removing the longstanding exclusion of ERISA-covered, self-insured group health plans from such requirements. Moreover, the recent amendment to the definition of "pharmacy benefit manager" does not, in any way, alter the extent to which ERISA's federal preemption framework prevents application of these state law provisions with respect to self-insured, ERISA-covered group health plans. The amendment merely clarifies that a plan that administers and manages its own pharmacy benefits is not considered a PBM.

[1] Notably, the Tenth Circuit also squarely rejected the State's argument that the state law in question was not preempted by ERISA because the law regulates PBMs rather than the actual health plan. *Id*. at 1194. Many courts have recognized that state laws regulating PBMs function as the regulation of an ERISA plan because most plans cannot operate without a PBM. *Id*. at 1195

Even as amended, HB 1584 continues to pose significant concerns under ERISA's preemption framework. The Supreme Court is currently considering the specific questions raised by the types of regulations at issue in HB 1584, and so the State's authority to regulate in this matter has not been finally determined. Adopting provisions that run afoul of longstanding state exclusions in advance of clarity by the courts will only inject uncertainty for the state's employers that have long relied upon this state law.

Accordingly, a number of provisions are likely preempted by ERISA based on existing Supreme Court jurisprudence, including *Rutledge*. In the following chart, we identify the specific provision, provide a description of the provision, and include the basis for federal preemption.

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
N.D. Cent. Code Ann. § 26.1-27.1-04(2) and 26.1-27.1-04(3) (proposed)	Requires PBMs to accept any pharmacy willing to accept the terms of the PBMs' contracts; requires that PBMs offer opt-in contracts.	This provision limits the ability of ERISA-covered plans to determine the scope of their pharmacy networks, which is inherent in the plan's benefit design. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted consistent with the holding in *Shaw*.
N.D. Cent. Code Ann. § 19-02.1-02(14) (applied to PBMs through § 26.1-27.1-04(1))	Prohibits a PBM from requiring a different drug or brand of drug to be dispensed in place of the drug or brand of drug ordered or prescribed without the express permission in each case of the person ordering or prescribing.	This limits the ability of plans to adopt formulary designs that utilize lower cost, therapeutic equivalents. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
N.D. Cent. Code Ann. § 26.1-27.1-05	Proscribes the payment terms that PBMs must offer their clients.	This provision could impose acute *and* direct economic burden on plans because it could limit the ability of plans to enter into high-value contracts Moreover, it could directly conflict with ERISA's fiduciary duty to act solely in the interest of the plan. As a result, the provision addresses a central matter of plan administration and fiduciary obligation, and should be preempted per *Gobeille*.

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Senate Industry and Business Committee
HB 1584 – 3/31/25 – 2:30pm
Senator Jeff Barta – Chairman

Chairman Barta and members of the Senate Industry and Business Committee, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1584.

HB 1584 looks to address a legal concern, changes to the marketplace and how can North Dakota create a process for enforcing existing PBM laws. In the very first definition (covered entity page 1 – lines 16-18), explicitly exempting self-funded ERISA plans in the law, could preempt the entire law. I have summarized the two 8th Circuit cases below that deal with a state law when it exempts ERISA self-funded plans by reference in the law.

1ST Case - Prudential Ins. Co. of Am. v Nat'l Park Med. Ctr., Inc. 154 F.3d 812, 822-26 (8th Cir. 1998)

The court concluded, first, that if a state law contains a "reference to" ERISA plans by singling out such plans for special treatment, such as, an exemption from the law, there is an established "reference to" and therefore preempted under federal law.

2nd Case – PCMA (PBMs) v. Gerhart (Iowa) 852 f.3d at 729 (8th Cir. 2017)

The same logic from 1998 was used in this PBM case. Iowa passed some PBM laws and in the laws, they exempted self-funded ERISA plans. Because Iowa had a "reference to" ERISA plans in their law, even though it was to exempt them from the law, the State of Iowa lost to the PBMs. The laws were preempted under ERISA because they had a "reference to" ERISA by explicitly exempting self-funded ERISA plans in their law. Crazy I know and I do not agree with the 8th Circuit, but that has been their position twice. The US Supreme Court has never addressed the 8th Circuit position related to directly exempting ERISA plans causes federal preemption. The 8th Circuit's standard for an express

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reference to ERISA therefore remains good law. This is why it is important to remove language that directly exempts ERISA plans.

Opinion letter by Attorney General Paxton (TX) concluding that ERISA does not preempt two recent Texas laws that regulate PBMs: (February 5, 2025)
https://www.texasattorneygeneral.gov/opinions/ken-paxton/kp-0480?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

The opinion is helpful in a number of ways: First, I think it is a well-reasoned analysis of why ERISA does not preempt the PBM laws at issue in Texas. Second, you will notice in his opinion, Paxton sights PBM laws in Texas where there is no reference to or exemption for ERISA plans in the PBM laws. Therefore, his opinion letter concludes the laws are not preempted. I also think his opinion is helpful because AG Paxton, is a conservative heavy weight.

On page 2 – Lines 17-19

Language is added to include rebate aggregators. What is a rebate aggregator? A rebate aggregator is often owned by the PBM or affiliated with the PBM. Two of the three main rebate aggregators are located outside the United States with one being Ireland and the other in Switzerland. We feel most of the rebate model has shifted in favor of rebate aggregators. If we are asking for information on rebates, it is important to gather information on rebate aggregators since the Big 3 PBMs now own them. Rebate aggregators have a negative effect on the rebates that employer plans should be receiving. Through these overseas companies, PBMs are able to maximize rebate retention for the benefit of the PBM and not the plans or patients. Rebate aggregators retain a portion of the rebate amount as fees. PBMs also reclassify rebates as administrative fees through this process. It is not uncommon to see higher cost drugs with higher rebates prioritized on formularies over better value or lower costs. You will also find contract language that excludes rebates when drugs are filled by a PBM owned pharmacy, mail order or specialty mail order pharmacy.

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Plan Sponsor ALERT: Beware of Rebate Aggregators

FTC Expands PBM Investigation to PBM-Owned Rebate Aggregators/GPOs

Language is also added to verify how much of the rebate dollars were retained by the PBM.

Page 2 – Lines 23-24

Since this law was enacted, we have seen a lot of market changes, especially around fees pharmacies pay to PBMs. From 2010 to 2020, PBM fees charged to pharmacies increased 91,000%! That is not a typo. We would like to see other price concessions or financial payments that are paid by the pharmacy to the PBM also be reported.

According to the fiscal year 2022 budget justification (p.242) estimate sent to Congress by CMS, pharmacy DIR fees increased by 91,500 percent between 2010 and 2019. For context, a $4 gallon of milk increased by that much would cost $3,660. (NCPA).

Page 3 – Lines 7 - 15

We support changing the definition of pharmacy benefits manager as amended in the House to reflect the concerns raised by self-funded pools/trust. By making this change, we can avoid or lessen concerns around ERISA preemption. This amendment was suggested by Mr. Robert Smith an expert ERISA attorney the State of ND hired to defend our PBM reform laws when the state was sued by the PBMs.

Section 2 – Bottom of page 3 (line 23) through page 4 (line 27)

This section provides for a formal process for licensing PBMs in North Dakota. This section also establishes the condition, terms, fees and application process to bring oversight under the ND Insurance Commissioner's office. This section was offered by the ND Insurance Commissioner's office as an amendment in the House which the House added to the bill to formalize the process for

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oversight of PBMs in ND. The ND Insurance Commissioner's office is the best place for authority over PBM practices and is considered a best practice for enforcement of state PBM laws.

Page 5 – Lines 2-3

Twenty years ago, when this law was passed, the "substitution of one prescription drug for another" was really the only other PBM related law under 19-02.1, Since the passage of that law, the ND Legislative Assembly has passed a number of other PBM reforms and they are placed under 19-02.1. HB 1584 would help bring the rest of the PBM laws in 19-02.1 under enforcement of the Insurance Commissioner.

Page 5 – Lines 10-14

HB 1584 adds two more provisions dealing with PBM contracting practices. In recent years, the PBMs have started to offer "silent agreement" contracts. They basically send out a fax or email and state "if we do not hear from you in the next 14 days, the pharmacy will automatically agree to the terms and conditions." HB 1584 looks to add language that requires a signature from the pharmacy and PBM before a contract is finalized and agreed upon.

HB 1584 also looks to provide the ability of a pharmacy to opt-out of a PBM contract giving a 90-day notice. We are seeing PBMs trying to lock pharmacies into multi-year contracts with no reasonable opt-out structure. PBMs can drop a pharmacy from the network with little to no notice, so we feel it is fair that pharmacies are given a more reasonable way to opt-out of a PBM contract. Providing a 90-day notice should be a reasonable request.

Page 6 – Last Page – Enforcement and Penalties

This section would establish not only an enforcement pathway but provide some expertise and help to the insurance commissioner's office. There are a number of states that have placed PBM enforcement with their Insurance Commissioner. Maybe I am wrong, but I assume the ND Insurance

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Commissioner, Board of Pharmacy and ND Health & Human Services could enter into a meaningful agreement(s) to help ease the workload and help provide additional expertise. Depending on what the agreement(s) looks like, the Board of Pharmacy could help with fielding complaints, fact finding, hearings, etc. and then turn things over to the Insurance Commissioner for final review and any potential enforcement. The penalties section is kind of self-explanatory and should help with PBM compliance.

In conclusion, HB 1584 (1) cleans up language from twenty years ago, (2) removes language to help withstand legal concerns, (3) adds a couple of PBM reforms laws to address market changes, (4) provides a pathway for enforcement and (5) helps streamline enforcement efforts while attempting to help provide expertise to the Insurance Commissioner's office.

Thank you for your time and attention today. I am happy to try and answer any questions.

Respectfully Submitted,

Mike Schwab

Mike Schwab

NDPhA - EVP

NORTH DAKOTA
Insurance Department

HB 1584 NEUTRAL TESTIMONY

John Arnold, Deputy Commissioner

Senate Industry and Business Committee
March 31, 2025

Good afternoon, Chairman Barta and members of the Senate Industry and Business committee.

My name is John Arnold, Deputy Insurance Commissioner, and I'd like to thank you for hearing our Department's neutral testimony for House Bill 1584.

When considering what action to take in regulating Pharmacy Benefit Managers (PBMs), I urge the committee to first consider the goal of the regulation. Is the regulation intended to protect consumers, or is it intended to protect pharmacists? I am not suggesting that one of these goals is superior to the other, but the answer to the question should guide the regulatory discussion.

If the goal is to protect consumers, namely through the reduction in prescription drug prices, I am compelled to inform you that the experience of the handful of states that have been leaders in PBM regulation have not seen this goal come to fruition. This isn't to say that some form of regulation may be successful in attaining that goal, but we haven't yet seen what that regulation looks like. So, if the goal is to lower prescription drug prices, I would encourage your consideration to resist the urge to act and further explore possible avenues to do this.

If, however, the goal is to protect pharmacists and pharmacies, this type of regulation may be beneficial. Some of the states that have been early adopters of PBM regulation have seen pharmacists and pharmacies receive increased payment from PBMs. But again, consumers have not seen the direct benefit of this sort of regulation.

I believe that the answer to the question of what the goal of the regulation is vital because it should then inform which entity would be appropriate for implementing the regulation. The Insurance Department is first and foremost a consumer protection agency. We regulate the insurance industry from the perspective of safeguarding promises made to North Dakota's insurance consumers. While PBMs certainly interact with insurance companies, it is important to remember that they are neither insurance companies nor insurance producers. They are currently license as a third-party administrator, however that is to allow them to provide insurance companies with administrative services, not to pool and underwrite risk.

If the goal of the regulation is to protect pharmacists, then I would suggest that an entity that is more familiar with pharmacists, pharmacies, and the pharmaceutical industry may be the better fit. Given that, it may be appropriate for the legislature to consider whether it may be appropriate to evolve the Board of Pharmacy, perhaps to the extent of making it a state agency to alleviate conflicts of interest concerns that may arise from that entity regulating to the benefit of the members of the board, into a body that could license, regulate, and enforce PBMs.

Unfortunately, as I have already indicated, if the goal is to reduce costs for consumers I do not have a suggestion to offer the committee.

As drafted, HB 1584 requires the regulation of PBMs to include full compliance with chapter 19-02.1, the North Dakota Food, Drug, and Cosmetic Act. The Department of Health and Human Services already has enforcement authority for this chapter, including partial PBM regulation found in sections 16.1, 16.2, 16.3, and 16.5.

As drafted on page 6, lines 12-14, HB 1584 recognizes that three entities (the Insurance Commissioner, the Board of Pharmacy, and the Department of Health and Human Services) all currently have some touchpoint with PBMs. I respect the effort to utilize existing state resources rather than adding FTEs but relying on joint exercise of common powers agreements has two notable flaws. First, a lack of leadership. As drafted, the Insurance Commissioner is responsible for the implementation of HB 1584, however the Commissioner has no authority over the staff of the Department of Health and Human Services or the Board of Pharmacy. The Commissioner cannot address prioritization of work, scheduling, or performance issues in those agencies as it relates to duties of this bill. Second, the experience of other states has shown that the volume of work that such regulation requires dedicated and specialized staff. States that have passed PBM regulation laws without dedicated staff have had to add those staff in the subsequent legislative session.

I've testified in the past that the necessary resources rely less on the population of the state, and more on the population of PBMs, which is roughly even across the country. While our lower population than many states may well correlate with fewer prescriptions being filled, the number of complaints is less important than the grouping of the complaints by PBM and by type are likely uniform.

For example, I recently attended a conference and the Insurance Commissioner from Kentucky mentioned that in January alone her office received over 3,000 complaints. Given that North Dakota's population is approximately 17% of Kentucky's population, we could anticipate well over 500 complaints a month. Having staff sort the complaints is perhaps the only portion of the process that depends on population. One or two individuals may be able to process that volume of incoming complaints. Once sorted, we would envision needing a pharmacist and one or two attorneys to review the complaints and interact with PBMs. Additionally, we would anticipate the need for a company analyst and a fraud analyst. Irrespective of whether the Insurance Department fulfills this regulatory need or some other entity, we suggest that effective regulation requires five to seven dedicated staff. This is not an endeavor that can be spread between the existing staff of three separate entities.

Lastly, there is the Rutledge issue. I stand before you today not to imply that I have an opinion on the authority granted by Rutledge, nor to propose that the threat of a lawsuit should impact your decision as legislators, but just to suggest that since the courts seem to still be in the process of determining the full impact of the Rutledge ruling, we believe that it is prudent to amend the bill to state that the Attorney General is responsible for any litigation that may arise from the implementation of HB 1584. This is critical because we are a special funded agency and are

required to pay the Attorney General for legal services, if this law passes, and if this law ultimately gets challenged in court, we would then need to approach the Emergency Commission to seek funding for said lawsuit. In our opinion it would be easier to clearly define that the adjudication of this law up to the Attorney General.

Before completing my testimony, I would like to suggest the proposed amendment that I have included with my testimony. When your sister committee in the House was considering HB 1584 we had the opportunity to collaborate with the committee and added additional language to Section 2 pertaining to the licensure of PBMs. Unfortunately, this was the most work on the bill for which the impending crossover deadlines allowed. Since then, the Department has continued to work on HB 1584 to propose what we believe would be needed to successfully implement PBM regulation.

Please know that the sponsors of this legislation fully understand the resource requirements associated with its implementation. When the bill was heard in the House, the sponsors explicitly acknowledged those needs and assured us that the conversation around resources would take place in the Senate. In keeping with that commitment, we used the time during crossover to prepare for this very discussion. That's why we're here today. This is not a new or untested concept—either in North Dakota or in our neighboring states—and we have a strong understanding of the resources necessary to implement these changes effectively.

To that end, the amendment we are proposing reflects what we believe is necessary to carry out this legislation in a meaningful and responsible way. We recognize that it comes with a cost, and while the full impact is still evolving, the amendment provides the flexibility we need to respond to future regulatory demands that may arise from this body's actions.

Let me be clear: our appropriations request will be significant. However, instead of asking directly for the 7 to 8 full-time employees (FTEs) we believe will ultimately be necessary to regulate this new area of insurance, we've chosen a different approach. Our amendment asks for built-in flexibility—giving the department the ability to hire when needed, adapt to this evolving space, and manage implementation of a new PBM Division in a fiscally responsible way.

Before I walk through the specifics of the amendment, I must emphasize one crucial point: regulatory authority without the resources to support it will create unrealistic expectations—among pharmacies, consumers, and even policymakers. I can foresee a situation in which this body passes enhanced regulatory guidelines for a space where we currently have limited or no authority, but fails to provide the necessary support. The result would be frustration when the expected outcomes don't materialize—not due to lack of will, but lack of capacity.

With that understanding in place, I'll now walk you through the details of our fiscal amendment.

On page 1, Section 1 is being suggested following the passage of HB 1123, which was signed by the Governor on March 17. HB 1123 created uniformity with how fees charged by the

Commissioner are listed in code, and so we suggest this to meet that standard. The corresponding removal can be found on page 4.

On page 1, lines 19-20 we suggest re removal of "an employer" to strengthen potential challenges to the law under ERISA.

Page 3, line 13 corrects a misspelling.

Page 4 lines 4 and 6 corrects the oversight of not including an email address when drafting the original amendment in the House.

Page 4, lines 15-21 edits are being suggested in conjunction with the edits on page 1, Section 1 as a result of the passage of HB 1123.

Page 5, lines 4-6 enumerate the sections of the North Dakota Food, Drug, and Cosmetic Act with which PBMs must comply.

Page 6/7, Section 9 established the service of process procedure necessary to take administrative action against a regulated entity.

Page 7, Section 10 establishes the Attorney General as being responsible for the expenses of any challenges to the law.

Page 7, Section 11 establishes that the funds received from the Board of Pharmacy for the current prescription drug price disclosure program be deposited into the Insurance Regulatory Trust Fund.

Page 8, lines 5-13 establishes a continuing appropriation for the Insurance Regulatory Trust Fund.

Page 8, Section 13 repeals a section of code stating that PBMs are third party administrators.

Page 8, Section 14 repeals the prescription drug price transparency program.

Page 8, Section 15 grants the Commissioner authority to increase or decrease full time equivalent positions subject to the availability of funds for the upcoming biennium to implement the regulatory program.

Page 8, Section 16 transfers the funds from the current prescription drug price disclosure program to the Insurance Regulatory Trust Fund.

Page 8, Section 17 creates a January 1, 2026, effective date for what would now be Section 3 of the bill. This is due to the annual nature of the license being created.

Thank you, Chairman Barta and members of the committee. I am happy to try to answer any questions that you may have.

25.1281.02000

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1584

FIRST ENGROSSMENT

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

A BILL for an Act to create and enact four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 ~~and~~ , 26.1-27.1-07 , and 26.1-36.10-06, of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10; to provide a penalty; to provide a continuing appropriation, to provide a transfer; to provide an effective date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. One new subdivision to subsection one of section 26.1-01-07 of the North Dakota Century Code is created and enacted as follows:

For the initial application fee for a pharmacy benefit manager, an amount determined by the commissioner, which may not exceed ten thousand dollars. For each annual renewal, an amount to be determined by the commissioner, which may not exceed ten thousand dollars.

SECTION ~~1.~~2 AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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 selffunded 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, longterm care, or other -limitedbenefit- health insurance ~~policy~~policies or ~~contract~~contracts that do not include prescription drug coverage.

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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee; pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management

program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~ financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. 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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION ~~2.~~3. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from the commissioner under to this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website that includes a request for the following information:
   a. The identity, address, electronic mail address, and telephone number of the applicant;
   b. The name, business address, electronic mail address, and telephone number of the contact person for the applicant;
   c. If applicable, the federal employer identification number for the applicant; and
   d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.
3. The term of licensure is one year from April thirtieth through March thirty-first.
4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.
5. ~~The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars.~~ The applicant shall submit the fee with ~~an~~the initial application ~~and~~or renewal application for ~~registration~~licensure. The initial application fee ~~is~~and renewal fee are nonrefundable. ~~The commissioner shall return a renewal application fee if the renewal of registration is not granted.~~
6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.
7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each applicant and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.
8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION ~~3.~~4. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with subsections 19-02.1-01, 19-02.1-02, 19-02.1-14.2, 19-02.1-16, 19-02.1-16.1, 19-02.1-16.2, 19-02.1-16.3, 19-02.1-16.4, 19-02.1-16.5, and 19-02.1-16.6 in chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.
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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.
3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or entities contracting on behalf of pharmacies.
4. A pharmacy must be allowed to opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION ~~4.~~5. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.106. Examination of insurer- covered- entity.

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received from the pharmacy benefits manager has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract with a pharmacy benefits manager and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION ~~5.~~6. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~for implementation of this chapter.

SECTION ~~6.~~7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION ~~7.~~8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.
2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities or individuals for losses incurred as a result of the violation.
3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 9. A new section to chapter 26.1--27.1 of the North Dakota Century Code is created and enacted as follows:

Proceedings by commissioner - Service of process - Procedure.

The commissioner shall serve process upon any licensee in any action or proceeding instituted by the commissioner under this chapter by electronic mail to the electronic mail address maintained in section 26.1-27.1-02 or by United States mail to the licensee at the licensee's last-known address of record or principal place of business. Service of process under this section is complete upon electronic mailing or United States mailing.

SECTION 10. A new section to chapter 26.1--27.1 of the North Dakota Century Code is created and enacted as follows:

Attorney General.

The attorney general shall appear, represent, and defend against all lawsuits, actions, or proceedings brought against the state or commissioner in the commissioner's official capacity. If the attorney general determines that the attorney general or an assistant attorney general is unable to defend the commissioner, the attorney general shall contract a special assistant attorney general to represent the commissioner. The attorney general shall be responsible for all costs under this section.

SECTION 11. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Wholesale License Fee.

The State Board of Pharmacy shall deposit up to six hundred dollars of every wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the insurance regulatory trust fund.

SECTION ~~10.~~12. AMENDMENT – Continuing appropriation. Section 26.1-01-07.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-07.1. Insurance regulatory trust fund established.

1. There is hereby created a trust fund designated "insurance regulatory trust fund". The following amounts must be deposited in the insurance regulatory trust fund:
   a. All sums received under section 26.1-01-07.
   b. All sums received under section 26.1-01-07.2 from the insurance regulatory trust fund investments.
   c. All retaliatory fees imposed upon persons by the insurance department as authorized by law.
   d. All administrative penalties, fines, and fees collected by the commissioner from any person subject to this title.

e. Any other amounts provided by legislative appropriation.

2. The moneys so received and deposited in the insurance regulatory trust fund are reserved for use by the insurance department to defray the expenses of the department in the discharge of its administrative and regulatory powers and duties as prescribed by law ~~subject to the applicable laws relating to the appropriations of state funds and to the deposit and expenditure of state moneys. The insurance department is responsible for the proper expenditure of these moneys as provided by law.~~ and are provided on a continuing appropriation basis.

~~3. Except as otherwise provided by law, after the fiscal year has been closed and all expenses relating to the fiscal year have been accounted for, the office of management and budget shall transfer any fund balance remaining in the insurance regulatory trust fund that exceeds one million five hundred thousand dollars to the general fund.~~

SECTION 13. REPEAL. Section 26.1-27-01.1 of the North Dakota Century Code is repealed.

SECTION 14. REPEAL. Chapter 26.1-36.10 of the North Dakota Century Code is repealed.

SECTION 15. TRANSFER - EXEMPTION - FULL-TIME EQUIVALENT POSITIONS. ADJUSTMENTS. Notwithstanding any other provisions of law, the insurance commissioner may increase or decrease authorized full-time equivalent positions as needed, subject to availability of funds, during the biennium beginning July 1, 2025, and ending June 30, 2027. The insurance commissioner shall report to the office of management and budget and legislative council any adjustments made pursuant to this section.

SECTION 16. TRANSFER – DRUG PRICING FUND TO INSURANCE REGULATORY TRUST FUND. The office of management and budget shall transfer any balance in the drug pricing fund on the effective date of this Act to the insurance regulatory trust fund.

SECTION 17. EFFECTIVE DATE. Section 3 of this Act becomes effective January 1, 2026.

SECTION ~~8.~~ 18. EMERGENCY. This Act is declared to be an emergency measure.

Good afternoon, Chairman Barta and members of the Senate Industry and Business committee. My name is Megan Hruby and I am with Blue Cross Blue Shield of North Dakota (BCBSND.)

BCBSND is here today in opposition of HB 1584 on behalf of our 450,000 members, around 60% of whom are self-funded clients. Self-funded plans are generally made up by the state's largest employers who choose to self-fund their health plans in an effort to control costs.

As you may have heard me testify before, between 2022 and 2024, BCBSND has spent $845,233,023.79 on North Dakota State Legislature imposed health insurance mandates. We anticipate that with the addition of the 2025 mandates and Essential Health Benefit additions, that number will be over $1 billion. This legislative session there have been just under a dozen mandates proposed: infertility, cryopreservation, insulin caps, ground ambulance reimbursement, step therapy bills, copay coupons, dental insurance reform, two different bills to require coverage of GLP-1 medications for weight loss and HB 1584, relative to PBM regulation. Each legislative session we see more, not less, mandates introduced. If all the proposed bills passed due to pressure from advocacy and special interest groups went directly to the commercial market, policyholders would be facing consequences from spur of the moment public policy decisions costing hundreds of millions of dollars, with little or no ability to unwind the impacts.

Self-funded plans are governed by ERISA, and therefore not subject to state health insurance mandates. They get to choose the benefits they offer their employees. (see below SF v FI chart.)

Self-funded vs. fully-insured

Self-funded		Fully-insured
Employer assumes risk Employer provides health benefits directly to employees	**Assumption of Risk**	**Insurance carrier assumes risk** Employer purchases insurance from insurance company
Employers have the freedom to choose what they cover	**Who Picks Benefits?**	Carriers file plans with the DOI and offer to FI clients
Employer pays claims Carriers are third party administrator and receive admin fees in exchange for networks, claims processing, etc	**Who Pays?**	Employers and individuals pay premium to insurance company and carrier pays claims
Governed by federal law (ERISA)	**Who Regulates?**	Governed by state law and subject to state mandates

There are several provisions of HB 1584 that are similar to laws regulating PBMs, third party administrators and/or health insurers such as BCBSND in other states that courts have determined are preempted by ERISA. Notably, there are provisions of HB 1584 that mandate pharmacy network and contracting requirements that are similar to the laws successfully challenged in the *Mulready* (10th Circuit) case and certain reporting and disclosure requirements to the laws successfully challenged in the *Gobielle* (2016 US Supreme Court) case. Because these HB 1584 provisions could likewise be determined by a court to be preempted by ERISA, one of our concerns is the taxpayer funded lawsuit aimed at dismantling ERISA pre-emption that is certain to follow passage. Currently, the *Mulready* case previously mentioned is pending hearing at the US Supreme Court. Again, since there are provisions in HB 1584 similar to the laws at issue in *Mulready*, it would be wise to wait until resolution of that case at the US Supreme Court before passing similar legislation in North Dakota.

Our second concern is what this legislation accomplishes for the average North Dakotan. Will passage of this law lower prescription drug costs? That was not one of the arguments made by proponents. In other states where PBM regulation has passed, plans have reported their prescription drug costs increasing rather than decreasing.

Rather, we heard an argument about increasing fees and contract practices for pharmacists. Those things are unfair. But is it the responsibility of the North Dakota taxpayer to fund a premature lawsuit and support legislation to further protect pharmacists? There is no one forcing pharmacists to contract with unfair PBMs. North Dakota already has multiple layers of state mandated protection in place in for our pharmacists including pharmacy ownership laws, any willing pharmacy, mandated 340B pricing with no reporting requirements, and multiple PBM laws that impose several requirements including provisions that limit fees and copayments PBMs may charge, require the use of electronic quality improvement platforms, prohibit gag orders, and require certain disclosures. Is more government regulation the answer right now when we are still waiting for an answer on law passed in 2020?

PBM regulation is a very relevant topic right now, both at the state and federal level. The National Association of Insurance Commissioners (NAIC), National Conference of Insurance Legislators (NCOIL) and multiple other state policy platforms have all been looking at this issue for the last several years. They have taken testimony, worked on model legislation, and lobbied Congress. These groups continue to work through this challenge to come up with a well thought out solution – we urge this committee to let these entities work through the process rather than push through legislation that is likely to put the ND taxpayers in the position of footing the bill for a lawsuit that this legislation is likely to cause without any benefit to them.

With that Chairman Barta, I urge a Do Not Pass on 1584 and will stand for any questions.

JAMES COMER, KENTUCKY
CHAIRMAN

ONE HUNDRED EIGHTEENTH CONGRESS

JAMIE RASKIN, MARYLAND
RANKING MINORITY MEMBER

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY
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August 28, 2024

Patrick Conway, M.D.
Chief Executive Officer
Optum Rx
2300 Main Street
Irvine, CA 92614

Dear Dr. Conway:

The House Committee on Oversight and Accountability writes to provide you the opportunity to correct the record for statements made during your appearance before the Committee. On July 23, 2024, the Committee held a hearing titled "The Role of Pharmacy Benefit Managers in Prescription Drug Markets." As the Chief Executive Officer of Optum Rx, you were invited to testify.

During the hearing you testified that Optum Rx does not steer patients to PBM-owned pharmacies:

Exchange:

Congressman Fallon: Okay. And the same thing I would like to start with, Mr. Joyner, do your companies steer patients to affiliated pharmacies? Yes or no.

Mr. Joyner. We actually establish a variety of different network options.

Congressman Fallon: And again, at limited time, yes or no?

Mr. Joyner. So the answer is no.

Congressman Fallon: Okay. Dr. Kautzner?

Dr. Kautzner. No, sir. Our clients make the decision on what pharmacy networks they want to use for their patients.

Congressman Fallon: Dr. Conway?

Dr. Conway. No.[1]

This statement contradicts both the Committee's and Federal Trade Commission's (FTC) findings that Optum Rx, as well as Express Scripts and CVS Caremark, steer patients to PBM-owned pharmacies.

The FTC interim staff report states that "vertically integrated PBMs may have the ability and incentive to prefer their own affiliated businesses" to "increase utilization of certain drug products at affiliated pharmacies to generate the greatest revenue and profits for their respective conglomerates."[2] PBMs accomplish patient steerage in different ways, including pharmacy network and formulary design. For example, the FTC reports that "PBMs routinely create narrow and preferred pharmacy networks that can advantage their own pharmacies while excluding rivals."[3] Additionally, the FTC reports that PBMs have multiple "optimization levers" to steer patients to PBM-owned pharmacies, including "white bagging," or requiring that patients obtain drugs from a PBM-affiliated pharmacy, and "brown bagging," which requires that a patient is administered a prescription in the provider's office instead of a patient's pharmacy of choice.[4]

Additionally, you testified that Optum Rx reimburses Optum Rx-affiliated pharmacies the same or more than non-affiliated pharmacies in its network, while also acknowledging that affiliated pharmacies are often the lowest cost option:

Exchange:

Congressman Fallon: Okay. Dr. Conway, have you all done this, where you are sending out unsolicited communications to pharmacies and saying if you don't respond, you are opted in, unless you opt out?

Dr. Conway: We do not participate in that type of contracting, and our independent pharmacy network has grown over the last several years. And we pay them more than retail pharmacies and actually pay non-affiliated pharmacies, on average, comparable or more than our affiliated pharmacies.

Congressman Fallon: So, would you say whether a pharmacy is owned by

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[1] *The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part III: Transparency and Accountability*, 118th Cong. (July 23, 2024).
[2] Federal Trade Commission, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, 3 (July 2024).
[3] *Id.* at 31-32.
[4] *Id.*

the same company as the PBM, is that a factor in determining reimbursement rates?

Dr. Conway: No. We pay affiliated and non-affiliated pharmacies comparable rates. Often our own affiliated pharmacies are actually the lowest cost options in the market, and at the end of the day, as described, the clients, employers, and others select the network that they want to provide to their employees.[5]

This statement contradicts both the Committee's and Federal Trade Commission's (FTC) findings that Optum Rx, as well as Express Scripts and CVS Caremark, reimburse PBM-owned pharmacies at a higher rate than non-affiliated pharmacies. The FTC interim staff report found that PBMs reimburse affiliated pharmacies at significantly higher rates than non-affiliated pharmacies.[6] In its case study, FTC found that PBM reimbursements for affiliated pharmacies often exceed the National Average Drug Acquisition Cost (NADAC).[7] Additionally, post-sale adjustments to pharmacy reimbursements by PBMs have been found to significantly reduce reimbursements for unaffiliated pharmacies.[8]

Additionally, you testified that Optum Rx does not engage in opt out contracting:

Exchange:

Congressman Fallon: Okay. Dr. Conway, have you all done this, where you are sending out unsolicited communications to pharmacies and saying if you don't respond, you are opted in, unless you opt out?

Dr. Conway: We do not participate in that type of contracting, and our independent pharmacy network has grown over the last several years. And we pay them more than retail pharmacies and actually pay non-affiliated pharmacies, on average, comparable or more than our affiliated pharmacies.

The Committee has also reviewed documents titled "Notice Amendment" in which a pharmacy to accept an amendment to their contracts with Optum Rx altering Direct and Indirect Remuneration by simply submitting a claim.[9] Furthermore, the FTC's interim staff report states, "Independent pharmacies generally lack the leverage to negotiate terms and rates when enrolling

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[5] *Supra* n. 1.
[6] *Supra* n. 2 at 39.
[7] *Id.*
[8] *Id.* at 59.
[9] *Notice Amendment*, [*on file with the Committee*].

in PBMs' pharmacy networks, and subsequently may face effectively unilateral changes in contract terms without meaningful choice and alternatives."[10]

The Committee highlights 18 U.S.C. § 1001, which states, "in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully–…(2) makes any materially false, fictitious, or fraudulent statement or representation;…shall be fined under this title, imprisoned not more than 5 years."[11] The Committee also highlights 18 U.S.C. § 1621, which states, "having taken an oath before a competent tribunal, officer, or person, in any case in which a law of the United States authorizes an oath to be administered, that he will testify, declare, depose or certify truly, or that any written testimony, declaration, deposition, or certificate by him subscribed, is true, willfully and contrary to such oath states or subscribes any material matter which he does not believe to be true…is guilty of perjury and shall…be fined under this title or imprisoned not more than five years, or both."[12]

Please provide any necessary corrections to the record prior to September 11, 2024.

Sincerely,

James Comer
Chairman
Committee on Oversight and Accountability

[10] *Supra* n. 2.
[11] 18 U.S.C. § 1001.
[12] 18 U.S.C. § 1621.

Lawmakers revive PBM reporting bill after near-passage last session

The bill, which would also apply to TPAs, came close to becoming law in December but ran into resistance from Elon Musk.

By **Allison Bell** | March 12, 2025 at 10:20 AM

The U.S. Capitol rotunda. Photo: Diego M. Radzinschi/ALM

A Republican and a Democrat are bringing back a pharmacy benefit manager reporting bill that nearly became law during the 118th Congress.

Rep. Erin Houchin, R-Ind., and Rep. Joe Courtney, D-Conn., introduced a version of the Hidden Fees Disclosure Act bill for the 119th Congress Tuesday.

The text of the new version was not available at press time, but it's similar to the text of the earlier version, which would require a PBM serving a self-insured employer health plan to send the employer a report showing all compensation the PBM has received; detailed information about any rebate or discounts negotiated, including information about the amounts of rebates or discounts to be passed through to the employer or the plan participants; and information about the PBM-related compensation flowing to other firms providing services for the employer's plan.

Third-party administrators serving self-insured employer plans would also have to provide detailed reports on their activities.

TPAs would have to tell employers about rebates, discounts, fees coming in from and going to other service providers, and recoveries from service providers associated with overpayments, erroneous payments, incomplete payments, billing errors, fraud and other matters.

The House included the bill in the Lower Costs, More Transparency Act bill, a package that passed in the House by a 320-71 vote in December. The hidden fees bill and the rest of the package nearly became law as a large spending package in December, but it was eventually removed from the package after Elon Musk asked for congressional leaders to replace the original spending package with a much shorter package. Musk did not comment on the bills excluded from the spending package, and it's not known what he or President Donald Trump think about the PBM-related provisions that were left out.

Related: New 'must pass' House package includes employer plan PBM section

PBMs help insurers, self-insured employer health plans and other payers manage prescription drug

benefits.

PBMs contend that they are attracting criticism because of their success at holding down prescription drug prices and pharmacies' and wholesale distributors' profit margins.

PBMs' critics contend that a handful of big PBMs control too much of the market, operate in ways that weaken competition and keep too much of the discounts that they negotiate.

Houchin said the new hidden fees bill will help by making patients and policymakers aware of the true cost of prescriptions.

"Americans should never be blindsided by hidden costs in their health care," Houchin said.

The bill could have a good chance to move forward in the House.

Both Sen. Bill Cassidy, R-La., chairman of the Senate Health, Education, Labor and Pensions Committee and Rep. Brett Guthrie, R-Ky., chairman of the House

Energy and Commerce Committee, have expressed support for passing PBM legislation.

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https://www.hometownstations.com/news/ohio_headlines/ag-yost-secures-49-1-million-settlement-in-price-fixing-cases-involving-generic-drugs/article_eb1b34d1-59d7-46d0-9c82-50d49a19e1b9.html

AG Yost secures $49.1 Million settlement in price-fixing cases involving generic drugs

Press release written and provided by the Office of Ohio Attorney General Dave Yost
Mar 26, 2025

PHOTO: Prescription drugs, Photo Date: 02/29/2020
Credit: AL.Eyad / Flickr / CC BY 2.0

March 26, 2025, Press Release from the Office of Ohio Attorney General Dave Yost:

COLUMBUS, Ohio — Consumers who were charged too much for certain generic drugs may be eligible for compensation from a $49.1 million settlement with two manufacturers, Ohio Attorney General Dave Yost announced today.

Apotex of Toronto and Heritage Pharmaceuticals of Eatontown, New Jersey, were accused of participating in a long-running scheme to artificially inflate prices, manipulate markets, and limit competition for numerous generic prescription drugs.

Heritage Pharmaceuticals will pay $10 million as part of the settlement, which was filed Dec. 15, 2016, in the U.S. District Court for the District of Connecticut, in Hartford. Apotex's share of the settlement is $39.1 million, bringing the total to $49.1 million.

"This was a conspiracy to cheat the system – we won't tolerate collusion that inflates drug prices and harms Ohioans who rely on affordable medication," Yost said. "We are working to restore fair competition and hold wrongdoers accountable."

Consumers who purchased certain generic prescription drugs between May 2009 and December 2019 may be eligible for compensation. To check eligibility, visit www.AGGenericDrugs.com, call 1-866-290-0182 (toll-free), or email info@AGGenericDrugs.com.

AG Yost joined a coalition of nearly all states and territories that filed three major antitrust complaints against 30 corporate defendants and 25 individual executives.

- The first complaint, filed in 2016, included Heritage Pharmaceuticals, Apotex and 16 corporate defendants, two individual executives, and 15 generic drugs. Two former Heritage executives, Jeffery Glazer and Jason Malek, have since settled and are cooperating.
- The second complaint, filed in 2019, targeted Teva Pharmaceuticals, Apotex and 18 of the nation's largest generic drug manufacturers, naming 16 senior executives.
- The third complaint, filed in 2020, focuses on 80 topical generic drugs that account for billions of dollars in U.S. sales and names 26 corporate defendants and 10 individual defendants. Six pharmaceutical executives have settled in this case and are assisting in the litigation.

The cases are all built on evidence from several cooperating witnesses, along with a database of more than 20 million documents and millions of phone records showing communications among 600-plus sales and pricing executives in the generics industry.

The complaints describe an interconnected network of industry executives who secretly met at dinners and social gatherings and on private calls, using coded language such as "fair share," "playing nice in the sandbox," and "responsible competitor" to disguise illegal agreements. One key piece of evidence is a two-volume notebook kept by a cooperating witness, documenting secret discussions with competitors and internal meetings over several years.

A major win in the fight against corporate greed, this settlement highlights Ohio's commitment to protecting consumers from unlawful practices.

Katie Honigford
Anchor/Multimedia Journalist

jmkasper@amg-nd.com

From: HEALTH CARE un-covered <healthcareuncovered@substack.com>
Sent: Wednesday, March 26, 2025 10:58 AM
To: jmkasper@amg-nd.com
Subject: There is a Bi-Partisan Bill to Rein in PBMs and Lower Drug Costs. It's a Step in the Right Direction.

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There is a Bi-Partisan Bill to Rein in PBMs and Lower Drug Costs. It's a Step in the Right Direction.

Pharmacy benefit managers' business practices have led to soaring prescription drug prices that make life-saving medications unaffordable for millions of Americans.

WENDELL POTTER

MAR 26

READ IN APP

Members of Congress from both political parties have joined forces to reintroduce a bill aimed at reforming how pharmacy benefit managers (PBMs)

make their money at the expense of patients. As reported by *ALM Benefits Pro*, the Delinking Revenue from Unfair Gouging Act, or DRUG Act, would halt PBMs from tying their payments to the retail or wholesale prices of prescription drugs. Instead, PBMs would have to charge flat fees for their services — an approach that could reduce the financial incentives for PBMs to drive up drug prices.

As a reminder, PBMs are the middlemen between drug manufacturers and patients. While they have been around for years, the biggest are now owned by big insurance companies. Cigna, CVS/Aetna and UnitedHealth Group. Collectively, those companies control 80% of the market, and they have figured out how to maximize profits in numerous ways.

For many drugs, the PBMs are taking more money out of the pharmacy supply chain than either the drugs' manufacturers or our local pharmacies., The big insurer-owned PBMs often pocket a cut of the very price hikes they claim to negotiate down. Critics — like myself — have pointed out that PBMs benefit when drug prices go up **because their fees are often based on a percentage of those inflated costs.**

In more layman's terms: It's not in the PBMs financial interest to keep prices down.

The DRUG Act was reintroduced by Rep. Mariannette Miller-Meeks, M.D. (R-IA) along with her colleagues Rep. Nannette Barragan (D-CA), Rep. Nicole Malliotakis (R-NY), Rep. Brad Schneider (D-IL), Rep. Rick Allen (R-GA), and Rep. Donald Norcross (D-NJ).

"Pharmacy benefit managers have excessive influence over the prices patients pay at the pharmacy counter," said Rep. Miller-Meeks. "Local Iowa pharmacies are closing due to greedy PBM practices, impacting proximity and access to medications for Iowans. The DRUG Act will put downward pressure on

prescription drug prices and insurance premiums by removing the incentive for PBMs to drive up the list price of medications."

Upgrade to paid

The PBM's PR and lobbying organization, the Pharmaceutical Care Management Association, insists, of course, that the industry's critics are wrong, even as an untold number of Americans walk away from the pharmacy country without their medications even with an insurance card in their wallets.

A Step in the Right Direction

The bipartisan nature of the DRUG Act signals growing recognition — on both sides of the political aisle — that PBMs are part of the problem. Several other bipartisan bills have or soon will be introducted to rein in the unchecked power of PBMs and the insurance giants that own them. We will keep you posted on whether some or all of them can finally get across the finish line this year. You can be certain PCMA and the big insurance companies will be spending enormous amounts of the money we pay in premiums to kill them, but there appears to be real momentum.

FEDERAL TRADE COMMISSION
PROTECTING AMERICA'S CONSUMERS

For Release

FTC Releases Second Interim Staff Report on Prescription Drug Middlemen

Report finds PBMs charge significant markups for cancer, HIV, and other critical specialty generic drugs

January 14, 2025 |

Tags: Competition | Office of Policy Planning | generic drugs | Pharmacy Benefits Managers (PBM) | Health Care | Drug Stores and Pharmacies | Prescription Drugs

The Federal Trade Commission today published a second interim staff report on the prescription drug middleman industry, which focuses on pharmacy benefit managers' (PBMs) influence over specialty generic drugs, including significant price markups by PBMs for cancer, HIV, and a variety of other critical drugs.

Staff's latest report found that the 'Big 3 PBMs'—Caremark Rx, LLC (CVS), Express Scripts, Inc. (ESI), and OptumRx, Inc. (OptumRx)—marked up numerous specialty generic drugs dispensed at their affiliated pharmacies by thousands of percent, and many others by hundreds of percent. Such significant markups allowed the Big 3 PBMs and their affiliated specialty pharmacies to generate more than $7.3 billion in revenue from dispensing drugs in excess of the drugs' estimated acquisition costs from 2017-2022. The Big 3 PBMs netted such significant revenues all while patient, employer, and other health care plan sponsor payments for drugs steadily increased annually, according to the staff report.

"The FTC staff's second interim report finds that the three major pharmacy benefit managers hiked costs for a wide range of lifesaving drugs, including medications to treat heart disease and cancer," said FTC Chair Lina M. Khan. "The FTC should keep using its tools to investigate practices that may

inflate drug costs, squeeze independent pharmacies, and deprive Americans of affordable, accessible healthcare—and should act swiftly to stop any illegal conduct."

"FTC staff have found that the Big 3 PBMs are charging enormous markups on dozens of lifesaving drugs," said Hannah Garden-Monheit, Director of the FTC's Office of Policy Planning. "We also found that this problem is growing at an alarming rate, which means there is an urgent need for policymakers to address it."

Staff's latest report builds on a report issued by FTC staff in July 2024, which found that pharmacies affiliated with the Big 3 PBMs received 68% of the dispensing revenue generated by specialty drugs in 2023, up from 54% in 2016. The latest report analyzes a broader set of specialty generic drugs compared to two specialty generic drugs analyzed in the July 2024 report and finds that the Big 3 PBMs impose significant markups on a wide array of specialty generic drugs.

The FTC's second interim staff report analyzed all specialty generic drugs dispensed from 2017 to 2022 for members of commercial health plans and Medicare Part D prescription drug plans managed by the Big 3 PBMs for which the FTC has relevant data. This includes an analysis of 51 specialty generic drugs comprising 882 National Drug Codes, which include the generic versions of: Ampyra (used to treat multiple sclerosis), Gleevec (used to treat leukemia), Sensipar (used to treat renal disease), and Myfortic (used by transplant recipients).

Key Findings

The FTC's latest interim staff report is part of the Commission's ongoing study of the PBM industry. This report highlights several key insights gained from data and documents obtained from special orders the FTC issued in 2022 under Section 6(b) of the FTC Act, as well as from publicly available information:

- **Significant price markups:** The Big 3 PBMs imposed *markups of hundreds and thousands of percent on numerous specialty generic drugs* dispensed at their affiliated pharmacies—including drugs used to treat cancer, HIV, and other serious diseases and conditions. The Big 3 PBMs also reimbursed their affiliated pharmacies at a higher rate than they paid unaffiliated pharmacies on nearly every specialty generic drug examined.
- **Dispensing the most profitable drugs:** A larger, disproportionate share of commercial prescriptions for specialty generic drugs marked up more than $1,000

per prescription were dispensed by the Big 3 PBMs' affiliated pharmacies compared with unaffiliated pharmacies. Dispensing patterns suggest that the Big 3 PBMs may be steering highly profitable prescriptions to their own affiliated pharmacies (and away from unaffiliated pharmacies).

- **Over $7.3 billion of dispensing revenue in excess of NADAC:** The Big 3 PBMs' affiliated pharmacies generated over $7.3 billion of dispensing revenue in excess of their estimated acquisition cost, as measured by the National Average Drug Acquisition Cost (NADAC), on specialty generic drugs over the study period. PBM-affiliated pharmacy dispensing revenue in excess of NADAC increased dramatically at a *compound annual growth rate of 42 percent* from 2017-2021. In the aggregate, the *top 10 specialty generic drugs generated $6.2 billion of dispensing revenue in excess of NADAC* (85 percent of total).

- **Generating additional income via spread pricing:** In the aggregate, the Big 3 PBMs also separately generated an estimated $1.4 billion of income from spread pricing—i.e., billing their plan sponsor clients more than they reimburse pharmacies for drugs—on the analyzed specialty generic drugs over the study period.

- **Specialty generic drugs help drive parent healthcare conglomerates' operating income:** The top specialty generic drugs accounted for a significant share of the relevant business segments reported by the Big 3 PBMs' parent healthcare conglomerates. Operating income from the Big 3 PBMs' affiliated pharmacies dispensing of the analyzed *specialty generic drugs accounted for 12 percent of the aggregated operating income reported by the parent healthcare conglomerates' business segments* that include their PBM and pharmacy businesses in 2021.

- **Plan sponsor and patient drug spending increased significantly:** In 2021, the last year for which the FTC received full-year data for this study, plan sponsors paid $4.8 billion for specialty generic drugs, while patient cost sharing totaled $297 million. Between 2017 and 2021 plan sponsors and patient payments both increased at compound annual growth rates of 21% for commercial claims, and 14%-15% for Medicare Part D claims.

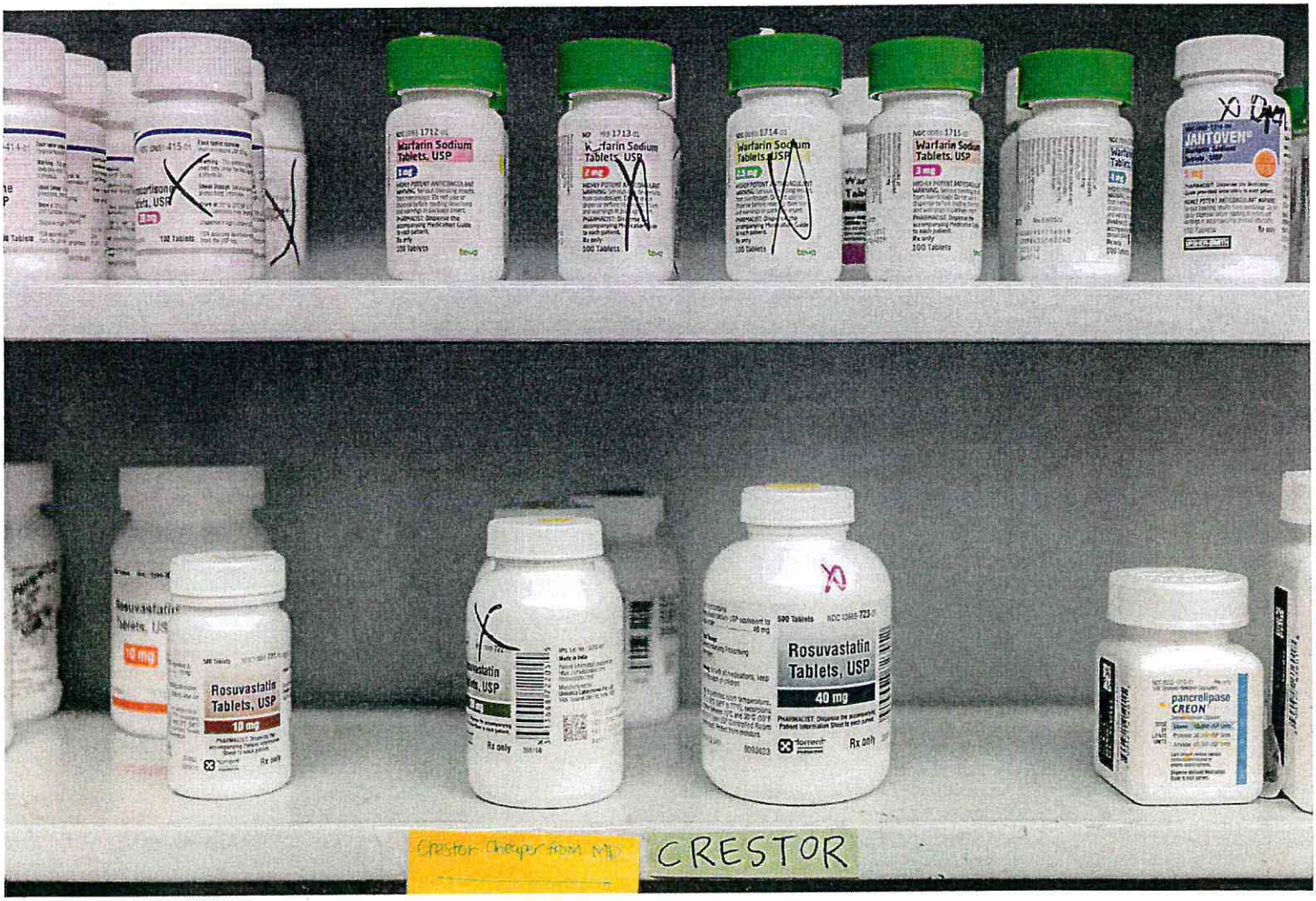
FTC staff remain committed to providing timely updates as the Commission continues to receive and review additional information as part of the ongoing study.

The Commission voted 5-0 to allow staff to issue the second interim staff report. Commissioner Andrew N. Ferguson issued a concurring statement joined by Commissioner Melissa Holyoak.

HEALTH

Optum audit shows possible law violation, lower payments to independent pharmacies

by Gwen Dilworth
November 7, 2024



Medications are lined up on a shelf at Brandon Discount Drugs in Brandon, Miss., on Thursday, Oct. 3, 2024. Independent pharmacies are facing financial challenges due to reduced reimbursements from the companies that serve as middlemen between pharmacies, drug manufacturers and insurers. Credit: Eric Shelton/Mississippi Today

The findings of a recent audit of a major company that manages prescription benefits revealed it may have violated Mississippi law.

The review of Minnesota-based Optum's business practices by the Mississippi Board of Pharmacy indicated that the company paid independent pharmacies in Mississippi rates lower than chains and Optum-affiliated pharmacies for the same prescription drugs.

The audit uncovered over 75,000 instances in which Optum-affiliated pharmacies' lowest payments for a prescription drug were higher than at unaffiliated pharmacies in one year, including chain and independent drug stores.

Mississippi state law prohibits pharmacy benefit managers from reimbursing their affiliate pharmacies, or ones they own, at higher rates than non-affiliate pharmacies for the same services.

In some cases, patients footed the bill: consumers were almost twice as likely to pay the full cost of a prescription drug claim without contributions from their insurance plan at independent pharmacies than at affiliated pharmacies.

The Board of Pharmacy will hold an administrative hearing based on the alleged violations of Mississippi law on Dec. 19. Board staff declined to answer questions about the audit or its findings.

"I think this proves that we need to have more transparency, we need to have more PBM reform in Mississippi and across the country and even on a federal level," said Robert Dozier, the executive director of the Mississippi Independent Pharmacy Association, an organization that advocates for 180 pharmacy members.

Optum declined to answer specific questions about the audit. The company has identified errors in the audit's findings and methodology and submitted them to the Board of Pharmacy, said Isaac Sorenson, a spokesperson for Optum.

"The pharmacy – and local pharmacists – play a vital role in supporting people's health and we are committed to paying them fairly," he said. "…For pharmacies in rural and underserved communities, Optum Rx is deepening its commitment to support their role by launching new programs, expanding existing initiatives and launching a new pharmacy network option for customers."

He said the new pharmacy network option will provide pharmacies with increased reimbursements. Generic drugs will be reimbursed at 5% higher rates and brand name drugs at .2% higher rates.

Optum is owned by health care behemoth UnitedHealth Group Inc., the U.S.' most profitable health care company and the owner of the nation's largest health insurance company, UnitedHealthcare. In 2023, the company **reaped $32.4 billion** in earnings.

Pharmacy benefit managers are private companies that act as middlemen between pharmacies, drug manufacturers and insurers. They process prescription drug claims, negotiate pricing and conditions for access to drugs and manage retail pharmacy networks.

Optum is one of the largest three pharmacy benefit managers in the U.S., which together account for 79% of prescription drug claims nationwide.

The results of the audit echoed some of the conclusions of a Federal Trade Commission **report** published in July: large pharmacy benefit managers pay their own, affiliated pharmacies significantly more than other pharmacies and set reimbursement rates at untenably low levels for independent drug stores, or retail pharmacies not owned by a publicly traded company or owned by a large chain, said the report.

Mississippi Today **reported last month** that many Mississippi independent pharmacists fear they may be forced to close their businesses due to low reimbursement rates from pharmacy benefit managers.

Pharmacy benefit managers have an incentive to steer customers towards their affiliate pharmacies and compensate them at higher rates, which can disadvantage unaffiliated pharmacies and lead to higher drug costs, said the Federal Trade Commission.

Optum's affiliate pharmacies include Optum Home Delivery Pharmacy and Optum Specialty Pharmacy.

The audit revealed that Optum uses 49 different maximum cost lists, or schedules created by pharmacy benefit managers that determine the highest price they will pay pharmacies for generic drugs. Maximum cost lists are proprietary and confidential, even to the pharmacies that are reimbursed based on the lists, and change continuously.

"I think that's 48 too many," said Dozier. "There should only be one MAC list."

Fifteen are used exclusively at independent pharmacies and 22 are used solely at chain pharmacies.

An analysis of the maximum allowable cost lists showed that independent pharmacies were reimbursed at rates 74% lower than chain pharmacies on average.

An analysis of a generic drug used to treat bacterial infections yielded a payment to an Optum-affiliated pharmacy that was eight times higher than the lowest-paid independent pharmacy on the same day. Chain and affiliate pharmacies were paid over 20 times as much as independent pharmacies for a generic drug used to treat stomach and esophagus problems.

Pharmacies' attempts to contest low reimbursement rates were often unsuccessful, showed the audit.

Ninety-eight percent of pharmacy appeals were denied, most commonly because they did not include information about how much the pharmacy paid to acquire the medication from a wholesaler.

Mississippi law prohibits pharmacy benefit managers from reimbursing pharmacies at rates below their cost to acquire the drug, even when using a maximum allowable cost list. But the audit revealed over 400 times that Optum denied pharmacies' appeals on those grounds, saying that the maximum cost list was accurate.

The audit, which studied Optum in 2022, was the first commissioned by the Mississippi Board of Pharmacy after **revisions to state law in 2020** gave it more regulatory authority over pharmacy benefit managers.

It took the board several years to hire staff to enact the law and receive approval to increase its budget due to the high costs of audits, the board's executive director Susan McCoy told lawmakers at the House Select Committee on Prescription Drugs Aug. 21 at the Capitol.

The board also has pending administrative proceedings with the other largest pharmacy benefit managers in the country, Express Scripts and CVS Caremark. Neither is the result of an audit. Both hearings are scheduled for Nov. 21.

Optum has already faced scrutiny for its business practices in Mississippi. In August, Attorney General Lynn Fitch **filed a lawsuit** alleging that Optum and several other pharmacy benefit managers stoked the opioid epidemic by plotting with manufacturers to increase sales of the addictive drugs and boost their profits. The suit also named Evernorth Health and Express Scripts, along with the companies' subsidiaries.

October 03, 2024 | Press Release

Attorney General Ken Paxton Sues Big Pharma Drug Manufacturers and Pharmacy Benefit Managers for Conspiracy That Increased Insulin Prices by 1,000%

Texas Attorney General Ken Paxton sued major insulin manufacturers and pharmacy benefit managers ("PBMs")—including Eli Lilly, Express Scripts, CVS Pharmacy, and others—over a conspiracy to increase prices of insulin.

Through this conspiracy, the manufacturers artificially and willingly raised the prices of insulin then paid a significant, undisclosed portion back to the PBMs as a *quid pro quo* for inclusion in the PBMs' standard offerings. The PBMs then granted preferred status to the manufacturer whose drug has the highest list price while excluding lower priced drugs. These synthetic insulin drugs, which today cost the manufacturers less than $2 to produce and were originally priced at $20 when released in the late 1990s, now range between $300 and $700. In the last decade alone, the manufacturers who are defendants in the lawsuit have increased the prices of their insulins up to 1,000%. Attorney General Paxton is suing because the insulin pricing scheme violates the Texas Deceptive Trade Practices Act, constitutes unjust enrichment, and represents an unlawful civil conspiracy.

"This is a disturbing conspiracy by which pharmaceutical companies were intentionally and artificially inflating the price of insulin. Big Pharma insulin manufacturers and PBMs worked together to take advantage of

diabetes patients and drive prices as high as they could," said Attorney General Paxton. "These companies acted illegally and unethically to enrich themselves, and we will hold them accountable."

According to the complaint, "While the PBM Defendants represent that they perform their services on behalf of their clients (including Texas payors) and diabetics to lower drug prices, increase access to affordable drugs, and promote diabetic health, these representations are false. Rather, the PBM Defendants have worked in coordination with the Manufacturer Defendants to distort the market for diabetic treatments to their benefit at the expense of Texas diabetics and payors."

Liston & Deas, David Nutt & Associates, the Cicala Law Firm, and Foreman Watkins Krutz are serving as outside counsel.

To read the filing, click here. (/sites/default/files/images/press/Eli%20Lilly%20et%20al%20Complaint%20Filestamped.

Back to Top

COMMENTARY

PBMs are modern-day drug price gangsters and must be held accountable

SARA SIROTA

APRIL 24, 2023 4:30 AM

(Stock photo Mint Images/Getty Images)

In March, Ohio Attorney General Dave Yost filed a groundbreaking lawsuit challenging the coercive tactics of the shadowy, modern-day health care mafia known as pharmacy benefit managers (PBMs). You may not have heard of PBMs before, but they play a

critical role in controlling which medications your insurer covers. While that may sound like a relatively minor job, PBMs have become the gatekeepers of the prescription drug industry, exploiting their monopoly power to jack up prices, limit access to affordable medicines, and line their pockets with billions of dollars in profit. Using behind-the-scenes negotiations and secret deals, this cartel has enriched themselves by extorting patients, pharmacies, and health care providers across the country.

The lawsuit targets Express Scripts and Prime Therapeutics – two of the largest PBMs in the U.S. Together, they control a mysterious and secretive company in Switzerland called Ascent, which Yost alleges is merely a front for a price-fixing conspiracy that would make even the Genovese crime family proud. Under Ascent's veil, Express Scripts and Prime Therapeutics agree to restrain competition and leverage their and client Humana's combined intelligence and market power to strong-arm manufacturers into raising prescription drug prices. The accusations are hardly a surprise for the PBM industry's longtime critics, who've yet to see much progress in the way of reform. But the lawsuit does arrive amid heightened momentum throughout the country, among Republicans and Democrats alike, in state legislatures and the U.S. Capitol, in attorneys general offices and the Federal Trade Commission, to crack down.

To understand what PBMs do, let's take a patient with attention deficit hyperactivity disorder (ADHD). The patient may find their health plan requires them to take Concerta, a drug that a 54 mg, 30-day supply costs a pharmacy about $419 to buy, rather than a generic equivalent, which costs just $26. Why would an insurer do this? Well, that decision was not up to the insurer. It was up to a PBM.

PBMs come up with the lists of medications that health plans cover each year for their beneficiaries. The idea is that PBMs can use the collective power of multiple plans to get price concessions from manufacturers in exchange for better rankings on the lists. The better the ranking, the more coverage the plan gives to that drug. Janssen Pharmaceuticals, Concerta's maker, can ensure the generic gets a worse ranking or is excluded entirely by offering the PBMs a larger rebate than the generic would ever be able to afford.

As Senate Finance Committee Chair Ron Wyden (D-OR) said during a hearing in late March, these are the "perverse incentives"

of the PBM business model: PBMs are paid a percentage of the rebate, so they're incentivized to give better coverage to more expensive drugs when coming up with their lists. This heightens drug spending not only by benefiting brand drugs over generics but by encouraging brand makers to compete with one another by continuously raising their prices.

Health plans are often not aware they're being fleeced because they have no idea what the real list and net prices are and how much of the rebates the PBMs are retaining. The PBMs claim all this data is proprietary, even though these are the very figures Express Scripts and Prime Therapeutics are allegedly sharing to fix the market. Since they've gotten away with claiming the information must be concealed, PBMs are also able to justify being the financial middlemen when a patient goes to the pharmacy counter to pick up their prescription. This gives them another avenue to skim profits, this time from independent pharmacies.

When the ADHD patient buys Concerta, for example, the PBM transmits the reimbursement from the health plan to the pharmacy, while taking a cut. This leaves the pharmacy with just $415 for the $419 drug, in addition to a $10 copay from the patient. That's already a slim margin for any business to operate on, let alone that PBMs often charge pharmacies additional fees they keep for themselves. They "are actually driving our independent pharmacies and our rural pharmacies into submission or gone," Senator James Lankford (R-OK) said during last month's hearing.

There's another perverse incentive in the PBM business model that's leading them to squeeze these drugstores into insolvency: they have their own mail-order pharmacies they'd rather steer patients to. This is just one type of "vertical integration" that Chair Lina Khan's FTC is probing as part of a sweeping investigation into the PBM industry. Representative Buddy Carter (R-GA) revealed at a House Energy and Commerce Committee hearing in March, though, that the PBMs are outrageously not cooperating. Beyond the conflicts of interest, just three PBMs – Caremark, Optum Rx, and Express Scripts – also control 80 percent of the industry, giving them what Senator Bob Menendez (D-N.J.) called "inappropriate negotiating leverage."

The floodgates are finally opening, but legislators and regulators must not squander this opportunity to enact half-baked measures. With payers facing mounting, unjustified bills each year, there's no

time to waste. To fix this, do not only impose transparency on the system. Address the underlying market failures by reversing the poorly conceived exemption from the Anti-Kickback Statute that PBMs were given more than 30 years ago so they could take rebates from manufacturers. Outlaw PBMs from having their own pharmacies and other conflicts of interest to clamp down on the absurd leverage the few giants have against their competitors and against health plans, patients, providers, and drug makers. As Ohio AG Yost said last week, "PBMs are modern gangsters... scheming in the shadows to control drug prices on all sides of the market."

Sara Sirota is a Policy Analyst at the American Economic Liberties Project.

SARA SIROTA

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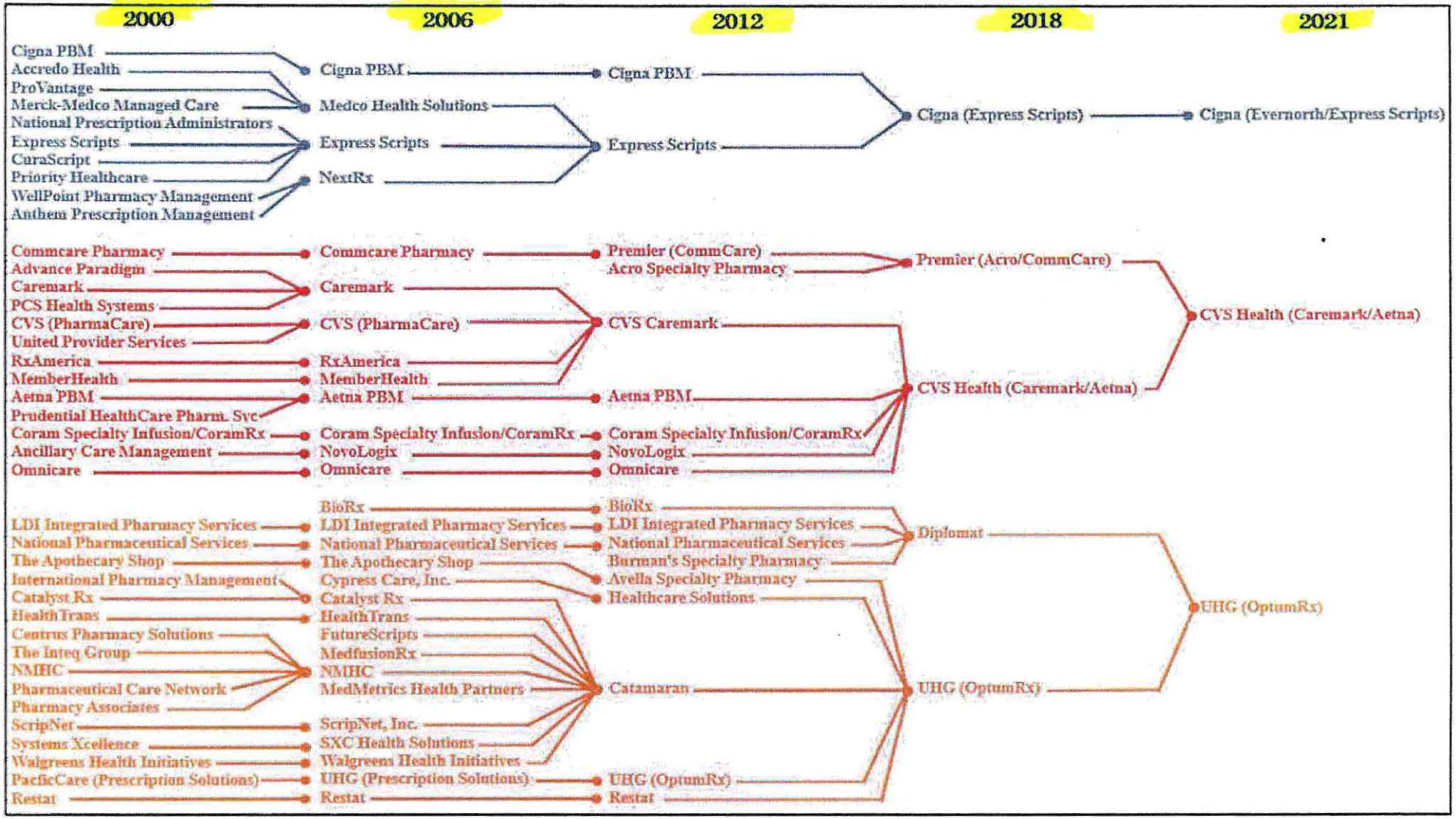
Figure 3. PBM Parent Entity Consolidation[21]



Prime Therapeutics ordered to pay $10 million for price fixing

By Kelcey Carlson | Published January 30, 2025 9:39pm CST | Health Care | FOX 9 |

The Brief

- Prime Therapeutics based in Eagan, MN ordered to pay $10 million in damages for pric fixing.
- This case stems from healthcare contracts with AIDS Healthcare Foundation (AHF) whic provides pharmacy care for people with HIV/AIDS.
- This was a federal arbitration case that said AHF was harmed by lower reimbursement rates from Prime for its drug costs.

(FOX 9) - Eagan-based Prime Therapeutics has been ordered to pay $10 millio in damages after federal arbitration found it engaged in illegal price fixing with competitor Express Scripts to suppress drug reimbursement rates for HIV/AID treatments.

The impact

Why it Matters: : Prime Therapeutics negotiates drug prices for insurance plans The arbitration found that Prime collaborated with a competi Express Scripts, in this price fixing agreement. And the ruling stated that Prime violated federal and Minnesota anti-trust laws in the process

Increased Scrutiny on Pharmacy Benefit Managers

The backstory: Prime Therapeutics and Express Scripts are both Pharmacy Benefit Managers or PBMs. The Federal Trade Commission is investigating the industry which is often in the same ownership chain with insurance companies. The federal investigation alleges that PBMs ar

inflating generic drug prices by 1,000 percent or more and squeezing out smal independent pharmacies.

Dig deeper: FOX 9 has been following the Federal Trade Commission investigat and filed this story in December with a look at how independent pharmacies were being impacted. You can also click here to read **t full Prime Therapeutics ruling.**

Reaction

Statement from the AIDS Healthcare Foundation

What they're saying: "Through this case and with this ruling, the Prime-ESI 'collaboration' has been clearly exposed as per-se-illegal horizontal price-fixing—the cardinal sin of antitrust law an felonious behavior that government antitrust enforcement agencies, including FTC, the Department of Justice's Antitrust Division, and U.S. State Attorneys General, should help put a nationwide end to immediately, for all victims," said **Jonathan M. Eisenberg,** AHF's Deputy General Counsel-Litigation and lead counsel for AHF in the arbitration. "We are fearful that Prime and/or ESI now w retaliate against AHF by kicking AHF out of their pharmacy networks. However, AHF took this risk in the pursuit of justice to expose the illegal price-fixing 'collaboration,' not just for ourselves but to speak out on behalf of everyone affected by this ongoing criminal activity, including thousands of independent pharmacies and tens of millions of patients across the United States."

Statement from Prime Therapeutics

What they're saying: In the arbitration brought by the AIDS Healthcare Foundat (AHF), Prime demonstrated how actual patients saved on prescription drugs as a result of the agreement. With this ruling, AHF is seeking to rewind the clock to cause patients living with HIV/AIDS pay more – not less – at their pharmacy and thereby enrich AHF's bottom line.

Generic prescription drug prices marked up as high as 5,000%, investigation finds

By Kelcey Carlson | Published February 2, 2025 10:49pm CST | Health Care | FOX 9 |

Report: Generic prescriptions marked up 5,000%

A new FTC report found that pharmacy benefit managers have inflated the pric of life-saving generic prescription drugs, finding the companies sometimes increased prices of these drugs by 1,000 percent or more.

The Brief

- The Federal Trade Commission (FTC) has found that some lifesaving generic prescriptic drug prices are being inflated, sometimes by 1000 percent or more.
- The FTC says this is the work of Pharmacy Benefit Managers (PBMs), three of which set pricing for 80 percent of prescriptions filled in the U.S. They are Express Scripts, CVS Caremark and Optum RX, based in Eden Prairie, MN.
- The price inflation happens when the Pharmacy Benefit Managers steer customers int

pharmacy systems they own, like mail order.

(FOX 9) - A new FTC report found that pharmacy benefit managers have inflate the price of life-saving generic prescription drugs, finding the companies sometimes increased prices of these drugs by 1,000 percent or more.

FTC Findings on drug prices

What we know: On January 14, 2025, the Federal Trade Commission released a second staff report into their findings of Pharmacy Benefit Manager price setting. The FTC specifically looked at generic dr for conditions like cancer, multiple sclerosis, HIV, transplants and pulmonary hypertension.

The report stated that: "Caremark, Express Scripts and OptumRX marked up numerous specialty generic drugs dispensed at their own affiliated pharmacies thousands of a percent, and many others by hundreds of a percent."

The report goes on to say, "such significant markups allowed the Big 3 PBMs ar their affiliated specialty pharmacies to generate more than $7.3 billion in reven from dispensing drugs in excess of the drugs' estimated acquisition costs from 2017 to 22."

FOX 9 looked further into the pricing in the report and found that a multiple sclerosis drug called Dalfampridine can be purchased for cash for about $10 a pharmacy counters or online through Cost Plus Drugs for a 30-day supply. But the FTC found that employers and customers through insurance plans get bille about $1,000 dollars for that same 30-day supply.

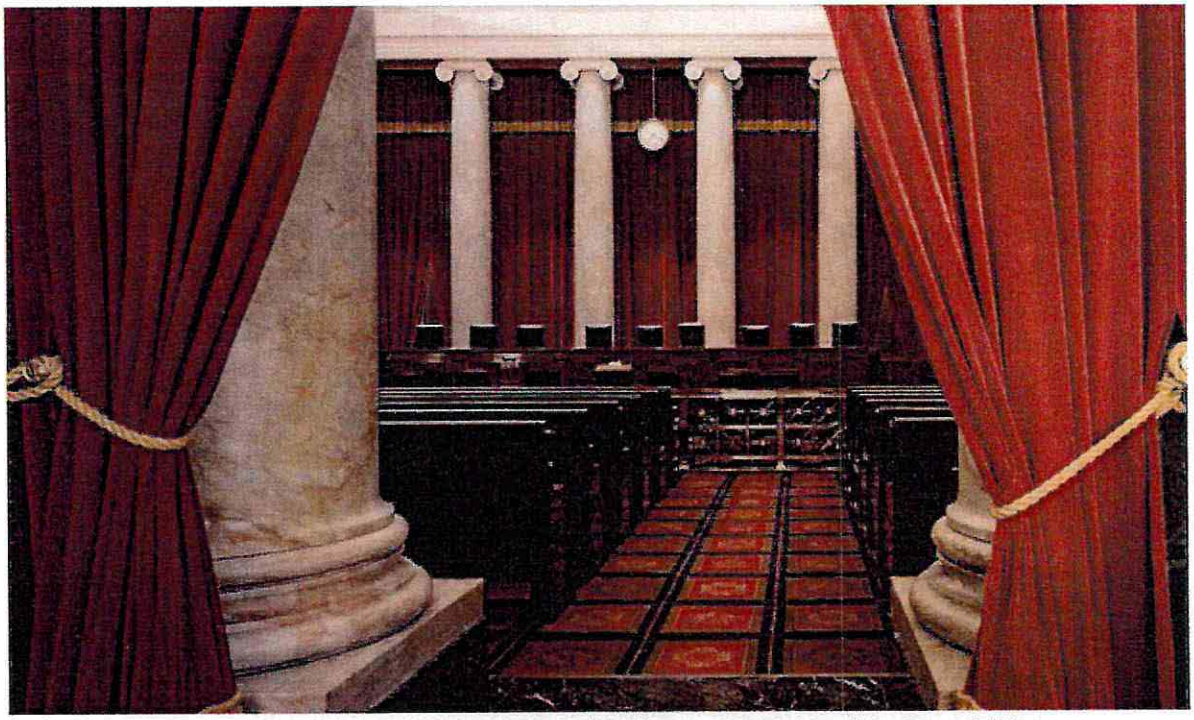
The cancer drug Imatinib can be purchased for cash at a pharmacy counter or online at Cost Plus Drugs for around $34.50 for a 30-day supply, but health pla

News

Supreme Court takes up PBM case: Does ERISA preempt states' efforts to regulate drug prices?

The Oklahoma case hinges on what happens when state authority collides with ERISA.

By **Allison Bell** | October 11, 2024 at 10:30 AM



U.S. Supreme Court courtroom in Washington, D.C. Credit: Carol M. Highsmith/Library of Congress via Wikimedia Commons

The U.S. Supreme Court plans to look at states' ability to regulate pharmacy benefit managers this term.

Glen Mulready, Oklahoma's insurance commissioner, is trying to overturn an appeals court ruling that found that the Employee

Retirement Income Security Act of 1974 benefits rule uniformity provisions preempts state efforts to regulate PBMs when the PBMs are serving self-funded employer health plans.

The Supreme Court "has long cautioned against stretching ERISA to preempt laws in 'traditionally state-regulated' areas about which 'ERISA has nothing to say,'" Mulready says in a brief filed in connection with the case, Mulready v. Pharmaceutical Care Management Association. "Pharmacy regulation is an area of traditional state concern and neither PBMs nor prescription-drug benefits are mentioned anywhere in ERISA."

But the PCMA, the PBMs' group, says ERISA should preempt the Oklahoma PBM law.

"This Court has said time and time again that any state law that 'prohibits employers from structuring their employee benefit plans in a [particular] manner" is 'clearly' preempted," the PCMA says.

Related: MetLife wins appeal in $65M health plan drug rebate case

Congress included the state-rule preemption provision ERISA in an effort to make U.S. benefits rules uniform.

Congress wanted to encourage large, multistate employers to offer benefit plans, by eliminating the need for multistate plans to comply with 50 different sets of benefit rules.

The PBMs contend that the play an important role in holding pharmacy benefit costs down.

State regulators and some other players, including traditional pharmacy groups, argue that the big PBMs are not transparent, may not really hold employers' costs down and are too hard on traditional pharmacies.

PCMA sued Oklahoma over its Patient's Right to Pharmacy Choice Act in the U.S. District Court for the Western District of Oklahoma in 2019.

A district court judge ruled in favor of Mulready and Oklahoma's PBM law in 2022.

The 10th U.S. Circuit Court of Appeals overturned the lower-court ruling in August 2023, finding that ERISA did preempt state efforts to regulate PBMs. 10th Circuit "NO"

A group of 32 state attorneys general, which includes both Republican attorneys general and Democratic attorneys general, is supporting Mulready.

The list of organizations submitting "friend of the court briefs" or comments, in support of Mulready also includes health care provider groups and pharmacy groups.

The Supreme Court previously ruled in favor of state efforts to regulate self-insured employers' PBMs in Rutledge v. Pharmaceutical Care Management Association.

SUPREME COURT "YES"

PCMA contends that the Rutledge ruling did not give states' new authority to regulate the benefits offered by ERISA plans.

25.1281.02002
Title.

Prepared by the Legislative Council staff for Representative Kasper
March 13, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1584

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

A BILL for an Act to create and enact two new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-01-07.1, 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06, and 26.1-27.1-07 of the North Dakota Century Code, relating to the insurance regulatory trust fund and pharmacy benefits managers; to provide a penalty; to provide for a transfer; to provide an exemption; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-01-07.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-07.1. Insurance regulatory trust fund established.

1. There is ~~hereby~~ created a trust fund designated as the "insurance regulatory trust fund". The following amounts must be deposited in the insurance regulatory trust fund:
   a. All sums received under section 26.1-01-07.
   b. All sums received under section 26.1-01-07.2 from the insurance regulatory trust fund investments.
   c. All retaliatory fees imposed upon persons by the insurance department as authorized by law.
   d. All administrative penalties, fines, and fees collected by the commissioner from any person subject to this title.
   e. Any other amounts provided by legislative appropriation.

2. The moneys ~~so~~ received and deposited in the insurance regulatory trust fund are reserved for use by the insurance department to defray the expenses of the department in the discharge of its administrative and regulatory powers and duties as prescribed by law subject to the applicable laws relating to the appropriations of state funds and to the deposit and expenditure of state moneys. The insurance department is responsible for the proper expenditure of these moneys as provided by law.
3. Except as otherwise provided by law, after the fiscal year has been closed and all expenses relating to the fiscal year have been accounted for, the office of management and budget shall transfer any fund balance remaining in the insurance regulatory trust fund that exceeds ~~one million~~three million dollars to the general fund.

SECTION 2. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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~~policies or ~~contract~~contracts that do not include prescription drug coverage.
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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee~~;~~, pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. 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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 3. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from ~~the~~ the commissioner under ~~to~~ this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website ~~that~~which includes a request for the following information:

   a. The identity, address, and telephone number of the applicant;

   b. The name, business address, and telephone number of the contact person for the applicant;

   c. If applicable, the federal employer identification number for the applicant; and

d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.

3. The term of licensure is one year, from April thirtieth through March thirty-first.

4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.

5. The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars. The applicant shall submit the fee with an application for registration. An initial application fee is nonrefundable. The commissioner shall return a renewal application fee if the renewal of registration is not granted.

6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.

7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each ~~applicant~~application and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 4. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.

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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.

3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or ~~entities~~an entity contracting on behalf of ~~pharmacies~~the pharmacy.

4. A pharmacy ~~must be allowed to~~may opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 5. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

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

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received ~~from the pharmacy benefits manager~~ has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract ~~with a pharmacy benefits manager~~ and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.
3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 6. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~for ~~implementation of~~to implement this chapter.

SECTION 7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.
2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities, pharmacies, or individuals for losses incurred as a result of the violation.
3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 9. TRANSFER - DRUG PRICING FUND TO INSURANCE REGULATORY TRUST FUND. On the effective date of this Act, the office of management and budget shall transfer any moneys in the drug pricing fund to the insurance regulatory trust fund for the purpose of enforcing the provisions of chapter 26.1-27.1.

SECTION 10. EXEMPTION - FULL-TIME EQUIVALENT POSITION ADJUSTMENTS - REPORT. Notwithstanding any other provision of law, the insurance commissioner may increase or decrease authorized full-time equivalent positions, subject to the availability of funds, during the biennium beginning July 1, 2025, and ending June 30, 2027, for the purpose

of enforcing the provisions of chapter 26.1-27.1. The insurance commissioner shall report to the office of management and budget and legislative council any adjustments made pursuant to this section.

SECTION 11. EMERGENCY. This Act is declared to be an emergency measure.

Prescription Benefits Manager Optum Rx Refuses to Provide Requested Data to State Auditor's Office

<< All News

Thursday, February 2, 2023 - 02:50pm
Categories: *News Releases*

On April 30, 2021, state lawmakers passed House Bill 1004 which required the State Auditor's Office to hire a third-party contractor to conduct a performance audit on the prescription drug coverage of NDPERS. The third-party contractor hired was Myers and Stauffer. The reason why a third-party contractor would be required for this audit was because of the complex and specialized nature of the report.

NDPERS is the organization that administers benefits e employees. One of those benefits is

healthcare. Sanford Health is the entity that provides healthcare to state employees. Sanford contracts with a third-party prescription benefits manager, called Optum Rx to manage pharmacy benefits for state employees. Their main responsibility is processing and paying prescription drug claims. They also negotiate discounts and rebates with drug manufacturers, contract with pharmacies, and maintain drug formularies.

In the audit, there were five different areas of opportunity to improve upon. These are called "findings" by auditors. All of the findings related to Optum Rx refusing to provide the information necessary to complete the audit. In the NDPERS contract with Sanford – as well as two sections of state law (N.D.C.C. 54-52.1-04.16, and N.D.C.C. 54-10-19) – both Sanford and Optum Rx are required to provide information and data upon request to complete this audit.

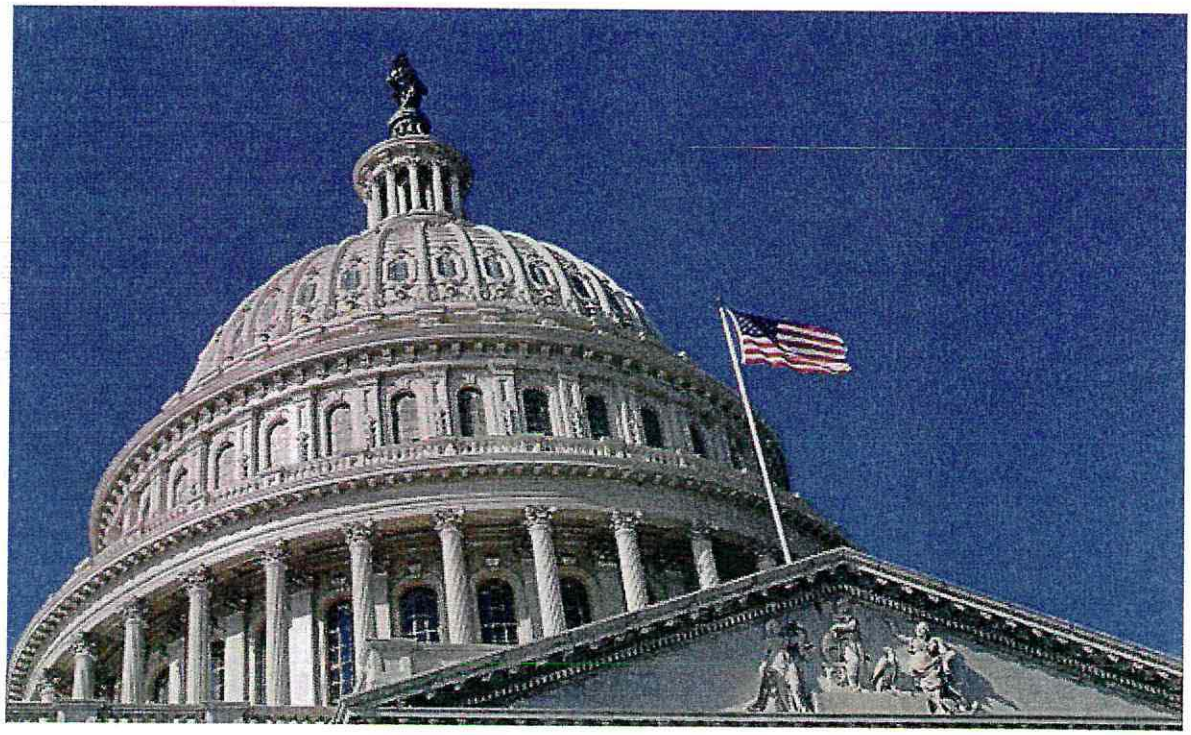
The number of people who fall under the NDPERS health plan totals over 49,000. This number includes state employees, retirees, and their dependents.

"The fact that an organization thinks it's big enough to refuse to give information necessary for an audit is offensive." Said State Auditor Joshua Gallion. "It's offensive to the lawmakers, it's offensive to state employees, and it's offensive to North Dakota taxpayers who deserve to know how their money is being spent."

House members roll out bipartisan PBM drug price transparency bill

A pharmacy benefit manager that fails to give employer plans detailed information could face a steep fine of $100,000 per violation.

By **Allison Bell** | March 28, 2025 at 11:09 AM



Credit: doganmesut/Adobe Stock

Two Republicans and two Democrats joined together Thursday to introduce a bill that could create extensive new reporting requirements for pharmacy benefit managers that serve employer plans.

The new Prescription Drug Transparency and Affordability Act bill would apply to PBMs that serve both employers with self-insured plans and employers with fully insured group health coverage.

Rep. Kristen McDonald Rivet, D-Mich., is the lead sponsor. The original cosponsors are Rep. Buddy Carter, R-Ga.; Rep. Robert Menendez, D-N.J.; and Rep. John James,

R-Mich.

"With this bill, we're bringing much-needed transparency to how drugs are priced in this country," McDonald Rivet said.

The bill is under the jurisdiction of the House Energy and Commerce Committee, the House Education and the Workforce Committee and the House Ways and Means Committee.

The backdrop: PBMs help insurers, employers and other payers run prescription benefits programs.

Pharmaceutical manufacturers, pharmacies and other prescription drug markets have argued that large PBMs that own their own pharmacies are making deals that end up increasing their own revenue, rather than passing any savings negotiated on to the payers or the patients.

The PBMs contend that the other players are angry about their successful efforts to hold down increases in prescription costs and squeeze excessive profits out of drug costs.

The new PBM bill is based on PBM reporting provisions included in the Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act, 2025, a 1,547-page legislative package that was designed to keep the government running and get many popular bills through Congress.

Related: New 'must pass' House package includes employer plan PBM section

Congress scrapped that version and passed a much shorter bill, without any PBM provisions, after Elon Musk, a presidential advisor, objected to passing the original version.

Bill provisions: The new PBM bill is similar in some ways to the Hidden Fees Disclosure Act bill, which was reintroduced earlier this month.

One important difference involves the enforcement mechanism. The Hidden Fees bill includes no explicit penalty provision.

The new bill imposes a penalty of up to $100,000 for failures to provide the required information or cases in which PBMs knowingly provide false information.

"Applicable entities," such as group purchasing organizations, drug manufacturers, wholesalers and rebate aggregators, would have to provide the information PBMs need to create the reports.

PBMs would have to provide reports in a way that provides only summary information, not protected health information, such as specific patients' names and prescription use.

The PBM reports would have to provide information such as the contracted compensation paid by the plan for each covered drug; the contracted compensation paid to the pharmacy; whether each prescription was provided through a retail, mail-order or specialty pharmacy; the wholesale cost of each drug prescribed; the net price for a treatment after taking all remuneration and discounts into effect; and patients' total out-of-pocket spending.

FEDERAL TRADE COMMISSION
PROTECTING AMERICA'S CONSUMERS

For Release

FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices

Caremark, Express Scripts, Optum, and their affiliates created a broken rebate system that inflated insulin drug prices, boosting PBM profits at the expense of vulnerable patients, the FTC alleges

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September 20, 2024 |

Tags: Competition | Bureau of Competition | Nonmerger | Pharmacy Benefits Managers (PBM) | Health Care | Prescription Drugs

Today, the Federal Trade Commission brought action against the three largest prescription drug benefit managers (PBMs)—Caremark Rx, Express Scripts (ESI), and OptumRx—and their affiliated group purchasing organizations (GPOs) for engaging in anticompetitive and unfair rebating practices that have artificially inflated the list price of insulin drugs, impaired patients' access to lower list price products, and shifted the cost of high insulin list prices to vulnerable patients.

The FTC's administrative complaint alleges that CVS Health's Caremark, Cigna's ESI, and United Health Group's Optum, and their respective GPOs—Zinc Health Services, Ascent Health Services, and Emisar Pharma Services—have abused their economic power by rigging pharmaceutical supply chain competition in their favor, forcing patients to pay more for life-saving medication. According to the complaint, these PBMs, known as the Big Three, together administer about 80% of all prescriptions in the United States.

The FTC alleges that the three PBMs created a perverse drug rebate system that prioritizes high rebates from drug manufacturers, leading to artificially inflated insulin list prices. The complaint charges that even when lower list price insulins became available that could have been more affordable for vulnerable patients, the PBMs systemically excluded them in favor of high list price,

highly rebated insulin products. These strategies have allowed the PBMs and GPOs to line their pockets while certain patients are forced to pay higher out-of-pocket costs for insulin medication, the FTC's complaint alleges.

"Millions of Americans with diabetes need insulin to survive, yet for many of these vulnerable patients, their insulin drug costs have skyrocketed over the past decade thanks in part to powerful PBMs and their greed," said Rahul Rao, Deputy Director of the FTC's Bureau of Competition. "Caremark, ESI, and Optum—as medication gatekeepers—have extracted millions of dollars off the backs of patients who need life-saving medications. The FTC's administrative action seeks to put an end to the Big Three PBMs' exploitative conduct and marks an important step in fixing a broken system—a fix that could ripple beyond the insulin market and restore healthy competition to drive down drug prices for consumers."

Insulin medications used to be affordable. In 1999, the average list price of Humalog—a brand-name insulin medication manufactured by Eli Lilly—was only $21. However, the complaint alleges that the PBMs' chase-the-rebate strategy has led to skyrocketing list prices of insulin medications. By 2017, the list price of Humalog soared to more than $274—a staggering increase of over 1,200%. While PBM respondents collected billions in rebates and associated fees according to the complaint, by 2019 one out of every four insulin patients was unable to afford their medication.

The FTC's Bureau of Competition makes clear in a statement issued today that the PBMs are not the only potentially culpable actors – the Bureau also remains deeply troubled by the role drug manufacturers like Eli Lilly, Novo Nordisk, and Sanofi play in driving up list prices of life-saving medications like insulin. Indeed, all drug manufacturers should be on notice that their participation in the type of conduct challenged here raises serious concerns, and that the Bureau of Competition may recommend suing drug manufacturers in any future enforcement actions.

The PBMs Benefit from Higher List Prices

The PBMs' financial incentives are tied to a drug's list price, also known as the wholesale acquisition cost. PBMs generate a portion of their revenue through drug rebates and fees, which are based on a percentage of a drug's list price. PBMs, through their GPOs, negotiate rebate and fee rates with drug manufacturers. As the complaint alleges, insulin products with higher list prices generate higher rebates and fees for the PBMs and GPOs, even though the PBMs and GPOs do not provide drug manufacturers with any additional services in exchange.

The complaint further alleges that PBMs keep hundreds of millions of dollars in rebates and fees each year and use rebates to attract clients. PBMs' clients are payers, such as employers, labor unions, and health insurers. Payers contract with PBMs for pharmacy benefit management services, including creating and administering drug formularies—lists of prescription drugs covered by a health plan.

The PBMs' Chase-the-Rebate Strategy Reduced Patients' Access to Lower List Priced Insulins, the FTC Alleges

Insulin list prices started rising in 2012 with the PBMs' creation of exclusionary drug formularies, the FTC's complaint alleges. Before 2012, formularies used to be more open, covering many drugs. According to the complaint, that changed when the PBMs, leveraging their size, began threatening to exclude certain drugs from the formulary to extract higher rebates from drug manufacturers in exchange for favorable formulary placement. Securing formulary coverage was critical for drug manufacturers to access patients with commercial health insurance, the FTC alleges.

Competition usually leads to lower prices as sellers try to win business. But in the upside-down insulin market, manufacturers—driven by the Big Three PBMs' hunger for rebates—increased list prices to provide the larger rebates and fees necessary to compete for formulary access, the FTC's complaint alleges. According to the complaint, one Novo Nordisk Vice President said that PBMs were "addicted to rebates." While PBMs' rebate pressures continued, insulin list prices soared. For example, the list price of Novolog U-100, an insulin medication manufactured by Novo Nordisk, more than doubled from $122.59 in 2012 to $289.36 in 2018.

The complaint alleges that even when low list price insulins became available, the PBMs systematically excluded them in favor of identical high list price, highly rebated versions. As described in the complaint, one PBM Vice President acknowledged that this strategy allowed the Big Three to continue to "drink down the tasty ... rebates" on high list price, highly rebated insulins.

The PBMs Caused the Burden of High Insulin List Prices to Shift to Vulnerable Patients, the FTC Alleges

According to the complaint, as insulin list prices escalated, the PBMs collected rebates that, in principle, should have significantly reduced the cost of insulin drugs for patients at the pharmacy counter. Certain vulnerable patients, such as patients with deductibles and coinsurance, often must pay the unrebated higher list price and do not benefit from rebates at the point of sale. Indeed, they

may pay more out-of-pocket for their insulin drugs than the entire net cost of the drug to the commercial payer. Caremark, ESI, and Optum knew that escalating insulin list prices and exclusion of low list price insulins from formularies hurt vulnerable patients—yet continued to pursue and incentivize strategies that shifted the burden of high list prices to patients, the FTC's complaint alleges.

Caremark, ESI, and Optum and their respective GPOs engaged in unfair methods of competition and unfair acts or practices under Section 5 of the FTC Act by incentivizing manufacturers to inflate insulin list prices, restricting patients' access to more affordable insulins on drug formularies, and shifting the cost of high list price insulins to vulnerable patient populations, the FTC's complaint alleges.

The Commission vote to file an administrative complaint was 3-0-2, with Commissioners Melissa Holyoak and Andrew N. Ferguson recused.

NOTE: The Commission issues an administrative complaint when it has "reason to believe" that the law has been or is being violated, and it appears to the Commission that a proceeding is in the public interest. The issuance of the administrative complaint marks the beginning of a proceeding in which the allegations will be tried in a formal hearing before an administrative law judge.

The Health Care Division of the FTC's Bureau of Competition was responsible for this matter.

The Federal Trade Commission works to promote competition, and protect and educate consumers. The FTC will never demand money, make threats, tell you to transfer money, or promise you a prize. You can learn more about how competition benefits consumers or file an antitrust complaint. For the latest news and resources, follow the FTC on social media, subscribe to press releases and read our blog.

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Victoria Graham

Medicaid Managed Care Reform

States must reform their Medicaid managed care prescription drug benefits to protect Medicaid beneficiaries, taxpayers, and local community pharmacy businesses. Too much control over the Medicaid drug benefit has been ceded to managed care organizations (MCOs) and their pharmacy benefit managers (PBMs), who have been found to "employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."

MCOs and PBMs work for their own best interests, instead of the beneficiaries' or taxpayers' best interests. They engage in spread pricing, which "is inflating prescription drug costs that are borne by beneficiaries and by taxpayers." In Ohio and Kentucky, spread pricing allowed PBMs to pocket $224.8 million and $123.5 million respectively in one year. They create drug formularies and negotiate rebates that lead to the greatest value for themselves, instead of the state, leading New York to unnecessarily pay $605 million to its MCOs and PBMs over a four-year period. State investigations into MCO and PBM practices have led one MCO to set aside $1.1 billion to settle lawsuits alleging mismanagement of public funds paid to administer the Medicaid managed care prescription drug benefit.

The Solution: Increase PBM Transparency/Accountability and Ensure State Oversight of Medicaid Prescription Drug Benefits

1. Carve pharmacy benefits out of the Medicaid managed care program and administer the benefits through the fee-for service program

California, Missouri, New York, North Dakota, Tennessee, West Virginia, and Wisconsin have carved their pharmacy benefits out of the Medicaid managed care program. This move helped West Virginia save over $54.4 million and North Dakota save $17 million in one year by carving out of the managed care program. California estimates that the carveout will save at least $150 million a year. New York budgeted nearly $1 billion of savings in the first two years of its NYRx transition.

2. Require MCOs and PBMs to reimburse at the transparent fee-for-service rates

Fee-for-service Medicaid programs reimbursement rates are transparent and evidence-based. Recognizing the value to taxpayers of requiring transparent reimbursements in their Medicaid managed care programs, **Arkansas, Georgia, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Nebraska** (independents only), **New Mexico** (independents only) **North Carolina, and Ohio** (dispensing fees vary based on volume) require MCOs and PBMs to reimburse pharmacies at the same rates established under the fee-for-service program. If such transparent reimbursement methodologies were adopted nationwide, federal Medicaid spending would drop by almost $1 billion over 10 years.

3. Increase regulatory oversight over PBMs in the Medicaid managed care program

Some states have passed legislation giving Medicaid officials greater oversight over the PBM Medicaid managed care contracts.

- Single PBM: Kentucky, Louisiana, Mississippi, and Ohio now contract with a single PBM to administer their Medicaid managed care prescription drug benefits, allowing greater authority to oversee the administration of benefits. Kentucky saved $282.7 million in 2021-2022.
- Single PDL: Michigan, Ohio, and South Carolina adopted single preferred drug lists (PDL) to ensure that MCOs and their PBMs establish formularies that create the most value for taxpayers.

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- Pass-through pricing models: Alaska, Arkansas, Colorado, Delaware, Florida, Iowa, Idaho, Louisiana, Michigan, Oklahoma, Pennsylvania, Vermont, Virginia, and Washington incentivize pass-through pricing models by curtailing or prohibiting spread pricing. Approximately half of states prohibit spread pricing in their Medicaid managed care programs.

States have found that an excessive amount of taxpayer dollars remain with pharmacy benefit managers (PBMs).

The Centers for Medicare and Medicaid Services is concerned that PBMs' use of "spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers," and CBO estimates that moving to transparent pharmacy reimbursement and eliminating spread pricing will save $2 billion over 10 years.

- Pennsylvania: Between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion.
- Ohio: the state Auditor found that, of the $2.5 billion that's spent annually through PBMs on Medicaid prescription drugs, PBMs pocketed $224.8 million through the spread alone during a one-year period.
- Kentucky: In response to a state report that found state PBMs keep $123.5 million in spread annually, the Attorney General has launched an investigation into allegations that the PBMs have overcharged the state and discriminated against independent pharmacies.
- Louisiana: PBMs retained $42 million that was incorrectly listed as "medical costs."
- New York: An audit found the state unnecessarily paid $605 million to Medicaid managed care organizations and their PBMs over a four-year period, because "MCOs typically work with their PBMs to conduct their own clinical reviews to identify drugs that provide the greatest value to THEM and therefore should be placed on the drug formulary."
- Michigan: Drug price manipulation allowed PBMs to overcharge Michigan Medicaid by at least $64 million.
- Virginia: A state-commissioned report on Medicaid found PBMs pocket $29 million in spread pricing alone.
- Maryland: A state Medicaid report found PBMs pocket $72 million annually in spread pricing alone.
- Florida: A report found PBMs steer patients to PBM-affiliated pharmacies, and "when it comes to dispensing brand name drugs, MCO/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."
- Arkansas: A state-commissioned report found that PBMs in the Medicaid program reimbursed national chain pharmacies more (defined as greater than 5% difference) than regional chain and independent pharmacies for the same drug.[1]
- Illinois: an audit found $200 million of spread pricing in 2021-2022, revealing no monitoring of contracts, including reimbursement rates or rebates, and non-compliance with many statutory requirements.
- Oregon: a 2023 audit found insufficient transparency and compliance with highly inconsistent reimbursement, including twice as much reimbursement to PBM-owned pharmacies than to independent pharmacies for selected drugs.

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Greater North Dakota Chamber

GREATER NORTH DAKOTA CHAMBER
HB 1584
Senate Industry & Business
Chair Jeff Barta
April 1, 2025

Mr. Chairman and members of the Committee, my name is Arik Spencer, President and CEO of the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** to House Bill 1584.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing state government could do to help your business, **the number one answer was to make healthcare more affordable**. I'm before you today because our members indicate that HB 1584, in both its introduced form and the engrossed form, will increase their health insurance costs instead of making it more affordable.

The federal Employee Retirement and Income Security Act (ERISA) of 1974 was enacted to provide employers with the ability to provide a uniform set of benefits to employees in multiple states. It was also enacted to provide employers with all their employees in one state the ability to self-fund health benefits for employees in a way that allows the employer flexibility in determining the benefits that make the most sense for their employees. And employers who self-fund health benefits for their employees assume all the risk; therefore, such benefits or health plans should not be considered insurance nor subject to the state regulation of insurance.

In North Dakota, close to 430,000 people rely on employer-provided health insurance, which consists of close to 60% of North Dakota's workforce being covered under ERISA-regulated self-funded health plans. These plans are the backbone of our state's health care coverage. ERISA's uniformity is essential to enabling businesses to offer competitive benefits and maintain operational efficiency without the complexities of varying state mandates. For small and medium-sized businesses in particular, ERISA's protections are crucial for providing affordable and consistent benefits across their workforce.

Federal ERISA law and over 50 years of federal case law generally preempt state laws from regulating health plans organized via ERISA. The language of HB 1584 may appear, by some parties, to apply only to pharmacy benefit managers (PBMs). However, enacting this language would result in an illegal attempt by the North Dakota Department of Insurance (DOI) to regulate ERISA plans via PBMs.

Federal ERISA preemption remains broad as described in more detail via the attachment to this testimony. Any attempt to extend current or future anti-PBM or anti-payor state law to ERISA plans violates federal law. The North Dakota business community is alarmed about the potential negative impacts. Because it's plan sponsors (rather than PBMs, who often pass along the regulatory costs) and their employees (working beneficiaries) who ultimately bear the cost of these increased regulatory and benefit costs.

GNDC strongly urges a **DO NOT PASS** recommendation, and I will be happy to stand for questions.

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Supplemental Information regarding HB 1584 – a bill relating to PBMs and ERISA health benefit plans

Federal ERISA preemption

Congress enacted ERISA to provide a "uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 248 (2004). "[B]y mandating certain oversight systems and other standard procedures" pursuant to uniform federal rules, ERISA "make[s] the benefits promised by an employer more secure" for employees while at the same time reducing the administrative burdens for multi-state employers. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016).

To achieve this objective, Congress included a "comprehensive" express preemption clause in ERISA, *id.*, which was "intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Shaw v. Delta Air Lines*, 463 U.S. 85, 99 (1983). As a corollary, "[s]tates are precluded from regulating in a field that Congress, acting within its proper authority has determined must be regulated by its exclusive governance." *Arizona v. United States*, 567 U.S. 387, 399 (2012). By protecting plans from competing state laws, ERISA's preemption clause "minimiz[es] the administrative and financial burdens on plan administrators – burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001) (internal quotation omitted).

Consistent with this Congressional intent, it is well-established under current U.S. Supreme Court precedent that state laws may be preempted where they bear an impermissible "connection with" ERISA plans. This may occur where a state law "bind[s] plan administrators to [a] particular choice" concerning the substance of plan benefits. *Rutledge*, 141 S. Ct. at 480. Such provisions stand in contrast to mere "rate regulation[s]," which have "an indirect economic effect on choices made by . . . ERISA plans" but do not "bind plan administrators to any particular choice" concerning plan design. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 667 (1995). In addition, "state laws dealing with the subject matters covered by ERISA" also have a "connection with" ERISA plans and are preempted. *Shaw*, 463 U.S. at 98. Finally, state laws that "'govern[] a central matter of plan administration" have a connection with ERISA plans and are preempted. *Gobeille*, 136 S. Ct. at 943 (internal quotes omitted).

Recent Judicial Decisions in *Rutledge* and *Wehbi*

Rutledge did not alter the established legal framework for determining whether a law bears an impermissible "connection with" ERISA plans. Rather, it applied that framework to the targeted law in that case, Arkansas's Act 900 ("Act 900"), which regulated maximum allowable cost ("MAC") lists for generic drug reimbursements. The Court held that Act 900 was "merely a form of cost regulation" that "requires PBMs to reimburse pharmacies for prescription drugs at rates equal to or higher than the pharmacy's acquisition cost." 141 S. Ct at 481. Therefore, *Rutledge* categorized Act 900's MAC pricing requirement under its long-standing holding in *Travelers* that state cost regulations are not preempted by ERISA. Otherwise, the Court emphasized that benefit design, structure, coverage, and other central matters of plan administration would remain protected from conflicting state regulations.

Likewise, the Eighth Circuit's decision in *Wehbi* does not change fundamental ERISA preemption standards. Indeed, the court confirmed that state laws that "require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan

administrators to specific rules for determining beneficiary status,'" are preempted. *Id.* at 9 (quoting *Rutledge*, 141 S. Ct. at 480). The court ruled that there is no presumption against ERISA preemption and that, consistent with the D.C. Circuit's decision in *PCMA v. District of Columbia*, 613 F.3d 179, 188 (D.C. Cir. 2010), ERISA preemption applies to laws that regulate PBMs even if they do not regulate ERISA plans directly. *Wehbi* at 6-8.

In addition, the ERISA preemption analysis is fact-specific, and *Wehbi* is a narrow decision, limited to provisions in two unique North Dakota statutes, many of which were directed at pharmacies with only indirect impacts to PBMs and plans. By contrast, in both its introduced and current amended form, the language of HB 1584 would regulate PBMs and self-funded health plans in areas that affect central matters of plan administration, a core ERISA concern. Finally, *Wehbi* has limited persuasive impact, as it frequently relied on cursory reasoning that overlooked several important aspects of ERISA preemption analysis. For instance, the *Wehbi* court failed to recognize that state laws implicating self-funded ERISA plan provider networks strike at the heart of plan benefit design and are subject to preemption. *See Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003) (recognizing that state any-willing-provider law that restricts network design has a "connection with" ERISA plans).

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

HB 1584
4/1/2025

A bill relating to pharmacy benefits managers; to provide a penalty and to declare; and emergency.

3:04 p.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Vice-Chair Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Pharmacy Ownership Law
- Patient and employer protection provisions
- Enforcement and regulatory authority environment
- Emergency clause removal
- Health benefit plan definition
- Self-funded plans and ERISA Plans
- Labor unions and employee plans
- Pharmacy benefits manager definition
- Third party payer language removal
- Forced contract provisions
- Fairness for pharmacists

3:04 p.m. Lisa Feldner, Integrity Public Affairs, introduced the following speaker.

3:04 p.m. Sara Gerving, Associate General Counsel, Blue Cross Blue Shield ND, explained the proposed amendments to the committee and answered the committee's questions.

3:19 p.m. John Arnold, Deputy Commissioner, ND Insurance Department, answered the committee's questions.

3:24 p.m. Mike Schwab, ND Pharmacists Association, testified in favor and answered the committee's questions.

3:28 p.m. Chairman Barta closed the hearing.

Audrey Oswald, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

HB 1584
4/02/2025

A bill relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide a continuing appropriation; to provide a transfer; to provide an effective date; and to declare an emergency.

3:16 p.m. Chairman Barta called the meeting to order.

Members present: Chairman Barta, Vice-Chair Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Creation of a new PBM regulation division
- Fiscal note and additional FTE's
- Flexibility in hiring and attracting professionals
- Redefinition and clarification of fees
- Removal of "an employer" language and ERISA exemption
- Technical corrections
- ND Food and Cosmetics Act
- Service of process and administrative action
- Attorney general cost responsibility and potential lawsuits
- Wholesale license fees and the board of pharmacy
- Prescription Drug Price Transparency Program
- Insurance Regulatory Trust Fund as a continuing appropriation
- PBM licensure revenue
- Litigation pool and the Attorney General's Office
- Emergency Commission process

3:15 p.m. Jon Godfread, Insurance Commissioner, ND Insurance Department, answered the committee's questions.

3:20 p.m. John Arnold, Deputy Insurance Commissioner, ND Insurance Department, explained the proposed amendment to the committee and submitted testimony #44584.

3:47 p.m. Claire Ness, Chief Deputy Attorney General of ND, answered the committee's questions.

3:52 p.m. Representative Jim Kasper, District 46, answered the committee's questions.

3:55 p.m. Johnny Palsgraaf, General Counsel, ND Insurance Department, answered the committee's questions.

3:59 p.m. Jon Godfread, Insurance Commissioner, ND Insurance Department, answered the committee's questions.

4:01 p.m. Mike Schwab, ND Pharmacists Association, answered the committee's questions.

4:02 p.m. Mark Hardy, Executive Director, Board of Pharmacy, answered the committee's questions.

4:05 p.m. Senator Klein moved to adopt Amendment LC# 25.1281.02001 with the removal of section ten of the bill.

4:05 p.m. Senator Kessel seconded the motion.

Senators	Vote
Senator Jeff Barta	Y
Senator Keith Boehm	A
Senator Mark Enget	Y
Senator Greg Kessel	Y
Senator Jerry Klein	Y

Motion passed 4-0-1.

4:07 p.m. Senator Klein moved a Do Pass and be Rereferred to Appropriations As Amended.

4:08 p.m. Senator Kessel seconded the motion.

Senators	Vote
Senator Jeff Barta	Y
Senator Keith Boehm	A
Senator Mark Enget	Y
Senator Greg Kessel	Y
Senator Jerry Klein	Y

Motion passed 4-0-1.

Senator Barta will carry the bill.

4:09 p.m. Chairman Barta adjourned the meeting.

Audrey Oswald, Committee Clerk

25.1281.02003
Title.03000

Adopted by the Senate Industry and Business Committee
April 2, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

VC 4/2/25
1 of 10

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1584

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

A BILL for an Act to create and enact ~~two~~four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-01-07.1, 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide a continuing appropriation; to provide a transfer; to provide an effective date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-01-07 of the North Dakota Century Code is amended and reenacted as follows:

1. The commissioner shall charge and collect the following fees:
   a. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.
   b. For each original certificate of authority issued upon admittance and for each annual renewal thereof, one hundred dollars and for amendment to certificate of authority, or certified copy thereof, fifty dollars.
   c. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

d. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, one hundred dollars.

e. For filing of articles of merger, or copies thereof, thirty dollars.

f. For filing an annual statement, twenty-five dollars.

g. For filing the abstract of the annual statement of an insurance company for publication, thirty dollars.

h. For an official examination, the expenses of the examination at the rate adopted by the department. The rates must be reasonably related to the direct and indirect costs of the examination, including actual travel expenses, including hotel and other living expenses, compensation of the examiner and other persons making the examination, and necessary attendant administrative costs of the department directly related to the examination and must be paid by the examined insurer together with compensation upon presentation by the department to the insurer of a detailed account of the charges and expenses after a detailed statement has been filed by the examiner and approved by the department.

i. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits and for any renewal of the certificate, twenty-five dollars.

j. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which must be paid to the testing service.

k. For issuing a surplus lines insurance producer's or insurance consultant's license, one hundred dollars. For each annual renewal of a surplus lines insurance producer's or insurance consultant's license, twenty-five dollars.

l. For issuing an insurance producer's license, one hundred dollars.

m. For issuing a duplicate of any license or registration issued under this title, ten dollars.

n. For each insurance company appointment and renewal of an appointment of an insurance producer, ten dollars.

o. For each company application for admission, five hundred dollars, except applications for admission for county mutual, fraternal benefit, and surplus lines companies must be one hundred dollars.

p. For issuing a license and each annual renewal of a license to an insurance premium finance company, one hundred dollars.

q. For examining or investigating an insurance premium finance company, the actual expense and per diem incurred; but the per diem charge may not exceed fifty dollars.

r. For issuing and each annual renewal of a license to an advisory organization, fifty dollars.

s. For filing an individual insurance producer licensing continuation, twenty-five dollars.

t. For services provided by the state fire marshal.

u. For the initial application fee for a pharmacy benefit manager, an amount determined by the commissioner, which may not exceed ten thousand dollars. For each annual renewal, an amount to be determined by the commissioner, which may not exceed ten thousand dollars.

SECTION 2. AMENDMENT. Section 26.1-01-07.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-07.1. Insurance regulatory trust fund established - Continuing appropriation.

1. There is ~~hereby~~ created a trust fund designated as the "insurance regulatory trust fund". The following amounts must be deposited in the insurance regulatory trust fund:

   a. All sums received under section 26.1-01-07.

   b. All sums received under section 26.1-01-07.2 from the insurance regulatory trust fund investments.

   c. All retaliatory fees imposed upon persons by the insurance department as authorized by law.

   d. All administrative penalties, fines, and fees collected by the commissioner from any person subject to this title.

   e. Any other amounts provided by legislative appropriation.

2. The moneys ~~so~~ received and deposited in the insurance regulatory trust fund are reserved for use by the insurance department to defray the expenses of the department in the discharge of its administrative and regulatory powers and duties as prescribed by law ~~subject to the applicable laws relating to the appropriations of state funds and to the deposit and expenditure of state moneys. The insurance department is responsible for the proper expenditure of these moneys as provided by law.~~

~~3. Except as otherwise provided by law, after the fiscal year has been closed and all expenses relating to the fiscal year have been accounted for, the office of management and budget shall transfer any fund balance remaining in the insurance regulatory trust fund that exceeds one million dollars to the general fund~~and are provided on a continuing basis.

SECTION 3. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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~~policies or ~~contract~~contracts that do not include prescription drug coverage.
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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee~~;~~, pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. 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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 4. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from ~~the~~ the commissioner under ~~to~~ this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website ~~that~~which includes a request for the following information:

   a. The identity, address, electronic mail address, and telephone number of the applicant;

   b. The name, business address, electronic mail address, and telephone number of the contact person for the applicant;

c. If applicable, the federal employer identification number for the applicant; and

d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.

3. The term of licensure is one year from April thirtieth through March thirty-first.

4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.

5. ~~The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars.~~ The applicant shall submit the fee with ~~an~~the initial application or renewal application for ~~registration~~licensure. ~~An~~The initial application fee ~~is~~and renewal fee are nonrefundable. ~~The commissioner shall return a renewal application fee if the renewal of registration is not granted.~~

6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.

7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each ~~applicant~~application and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 5. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with subsections 19-02.1-01, 19-02.1-02, 19-02.1-14.2, 19-02.1-16, 19-02.1-16.1, 19-02.1-16.2, 19-02.1-16.3, 19-02.1-16.4,

19-02.1-16.5, and 19-02.1-16.6 in chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.

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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.

3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or ~~entities~~an entity contracting on behalf of ~~pharmacies~~the pharmacy.

4. A pharmacy ~~must be allowed to~~may opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 6. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

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

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received ~~from the pharmacy benefits manager~~ has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.

2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract ~~with a pharmacy benefits manager~~ and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 7. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~~~for implementation of~~to implement this chapter.

SECTION 8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 9. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.
2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities, pharmacies, or individuals for losses incurred as a result of the violation.
3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 10. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Proceedings by commissioner - Service of process - Procedure.

The commissioner shall serve process upon any licensee in any action or proceeding instituted by the commissioner under this chapter by electronic mail to the electronic mail address maintained in section 26.1-27.1-02 or by United States mail to the licensee at the licensee's last-known address of record or principal place of business. Service of process under this section is complete upon electronic mailing or United States mailing.

SECTION 11. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Wholesale license fee.

The state board of pharmacy may deposit up to six hundred dollars of every eligible wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the insurance regulatory trust fund.

SECTION 12. REPEAL. Section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code are repealed.

SECTION 13. EXEMPTION - FULL-TIME EQUIVALENT POSITIONS - ADJUSTMENTS. Notwithstanding any other provisions of law, the insurance commissioner may increase or decrease authorized full-time equivalent positions as needed, subject to availability of funds, during the biennium beginning July 1, 2025, and ending June 30, 2027, for the purpose of enforcing the provisions of chapter 26.1-27.1. The insurance commissioner shall report to the office of management and budget and legislative council any adjustments made pursuant to this section.

SECTION 14. TRANSFER - DRUG PRICING FUND TO INSURANCE REGULATORY TRUST FUND. On the effective date of this Act, the office of management and budget shall transfer any money in the drug pricing fund to the insurance regulatory trust fund for the purpose of enforcing the provision of chapter 26.1-27.1.

SECTION 15. EFFECTIVE DATE. Section 4 of this Act becomes effective January 1, 2026.

SECTION 16. EMERGENCY. This Act is declared to be an emergency measure.

REPORT OF STANDING COMMITTEE
ENGROSSED HB 1584

Industry and Business Committee (Sen. Barta, Chairman) recommends **AMENDMENTS (25.1281.02003)** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (4 YEAS, 0 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). Engrossed HB 1584 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

25.1281.02000

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1584

FIRST ENGROSSMENT

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

A BILL for an Act to create and enact four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact sections 26.1-01-07.1,26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 ~~and~~ , 26.1-27.1-07 , and 26.1-36.10-06, of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10; to provide a penalty; to provide a continuing appropriation, to provide a transfer; to provide an effective date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. One new subdivision to subsection one of section 26.1-01-07 of the North Dakota Century Code is created and enacted as follows:

For the initial application fee for a pharmacy benefit manager, an amount determined by the commissioner, which may not exceed ten thousand dollars. For each annual renewal, an amount to be determined by the commissioner, which may not exceed ten thousand dollars.

SECTION 2. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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 selffunded- 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, longterm care, or other -limitedbenefit- health insurance ~~policy~~policies or ~~contract~~contracts that do not include prescription drug coverage.

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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee~~;~~, pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management

program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity~~. ~~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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 3. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from ~~the~~ the commissioner under ~~to~~ this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website ~~that~~which includes a request for the following information:
   a. The identity, address, electronic mail address, and telephone number of the applicant;
   b. The name, business address, electronic mail address, and telephone number of the contact person for the applicant;
   c. If applicable, the federal employer identification number for the applicant; and
   d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.
3. The term of licensure is one year, from April thirtieth through March thirty-first.
4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.
5. ~~The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars.~~ The applicant shall submit the fee with ~~an~~the initial application ~~and~~or renewal application for ~~registration~~licensure. The initial application fee ~~is~~and renewal fee are nonrefundable. ~~The commissioner shall return a renewal application fee if the renewal of registration is not granted.~~
6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.
7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each ~~applicant~~application and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.
8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 4. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with subsections 19-02.1-01, 19-02.1-02, 19-02.1-14.2, 19-02.1-16, 19-02.1-16.1, 19-02.1-16.2, 19-02.1-16.3, 19-02.1-16.4, 19-02.1-16.5, and 19-02.1-16.6 in chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.
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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.
3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or ~~entities~~an entity contracting on behalf of ~~pharmacies~~the pharmacy.
4. A pharmacy ~~must be allowed to~~may opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 5. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.106. Examination of insurer- covered- entity.

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received ~~from the pharmacy benefits manager~~ has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract ~~with a pharmacy benefits manager~~ and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 6. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~for ~~implementation of~~to implement this chapter.

SECTION 7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.
2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities, pharmacies, or individuals for losses incurred as a result of the violation.
3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 9. A new section to chapter 26.1--27.1 of the North Dakota Century Code is created and enacted as follows:

Proceedings by commissioner - Service of process - Procedure.

The commissioner shall serve process upon any licensee in any action or proceeding instituted by the commissioner under this chapter by electronic mail to the electronic mail address maintained in section 26.1-27.1-02 or by United States mail to the licensee at the licensee's last-known address of record or principal place of business. Service of process under this section is complete upon electronic mailing or United States mailing.

SECTION 10. A new section to chapter 26.1--27.1 of the North Dakota Century Code is created and enacted as follows:

Attorney General.

The attorney general shall appear, represent, and defend against all lawsuits, actions, or proceedings brought against the state or commissioner in the commissioner's official capacity. If the attorney general determines that the attorney general or an assistant attorney general is unable to defend the commissioner, the attorney general shall contract a special assistant attorney general to represent the commissioner. The attorney general shall be responsible for all costs under this section.

SECTION 11. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Wholesale License Fee.

The State Board of Pharmacy may deposit up to six hundred dollars of every eligible wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the insurance regulatory trust fund.

SECTION 12. AMENDMENT – Continuing appropriation. Section 26.1-01-07.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-01-07.1. Insurance regulatory trust fund established.

1. There is ~~hereby~~ created a trust fund designated as the "insurance regulatory trust fund". The following amounts must be deposited in the insurance regulatory trust fund:

   a. All sums received under section 26.1-01-07.

   b. All sums received under section 26.1-01-07.2 from the insurance regulatory trust fund investments.

   c. All retaliatory fees imposed upon persons by the insurance department as authorized by law.

   d. All administrative penalties, fines, and fees collected by the commissioner from any person subject to this title.

e. Any other amounts provided by legislative appropriation.

2. The moneys ~~so~~ received and deposited in the insurance regulatory trust fund are reserved for use by the insurance department to defray the expenses of the department in the discharge of its administrative and regulatory powers and duties as prescribed by law ~~subject to the applicable laws relating to the appropriations of state funds and to the deposit and expenditure of state moneys. The insurance department is responsible for the proper expenditure of these moneys as provided by law.~~ and are provided on a continuing appropriation basis.

~~3. Except as otherwise provided by law, after the fiscal year has been closed and all expenses relating to the fiscal year have been accounted for, the office of management and budget shall transfer any fund balance remaining in the insurance regulatory trust fund that exceeds one million dollars to the general fund.~~

SECTION 13. REPEAL. Section 26.1-27-01.1 of the North Dakota Century Code is repealed.

SECTION 14. REPEAL. Chapter 26.1-36.10 of the North Dakota Century Code is repealed.

SECTION 15. EXEMPTION - FULL-TIME EQUIVALENT POSITIONS. ADJUSTMENTS. Notwithstanding any other provisions of law, the insurance commissioner may increase or decrease authorized full-time equivalent positions as needed, subject to availability of funds, during the biennium beginning July 1, 2025, and ending June 30, 2027, for the purpose of enforcing the provisions of chapter 26.1-27.1. The insurance commissioner shall report to the office of management and budget and legislative council any adjustments made pursuant to this section.

SECTION 16. TRANSFER – DRUG PRICING FUND TO INSURANCE REGULATORY TRUST FUND. On the effective date of sections of this Act, the office of management and budget shall transfer any money in the drug pricing fund to the insurance regulatory trust fund for the purpose of enforcing the provisions of chapter 26.1-27.1.

SECTION 17. EFFECTIVE DATE. Section 3 of this Act becomes effective January 1, 2026.

SECTION 18. EMERGENCY. This Act is declared to be an emergency measure.

2025 SENATE APPROPRIATIONS

HB 1584

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Government Operations Division
Red River Room, State Capitol

HB 1584
4/8/2025

A BILL for an Act to create and enact four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-01-07.1, 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide a continuing appropriation; to provide a transfer; to provide an effective date; and to declare an emergency.

3:18 p.m. Chairman Wanzek opened the hearing.

Members present: Chairman Wanzek, Vice-Chair Dwyer, Senator Burckhard, Senator Erbele, and Senator Sickler.

Discussion Topics:

- Role of pharmacy benefit managers (PBMs)
- Federal Trade Commission reports on PBMs
- Regulation of PBMs in other states
- Overview of PBM actions in North Dakota
- Role off ND Insurance Commission in regulating PBMs
- Drug rebate aggregators
- Etna, Signa, United Health - largest PBMs
- Process for accountability of PBMs
- Review process
- Enforcement and penalties
- Legal aspect of PBM regulation
- Self-funded insurance plans, ERISA, litigation cost
- Insurance Commission full-time employees and salaries needs for regulatory duties
- Funding sources directed to Insurance Regulatory Trust Fund
- Market Conduct Examination
- Federal role in regulation of PBMs
- Role of Employee Retirement Income Security Act (ERISA); expected Supreme Court ruling on PBMs

3:18 p.m. Mike Schwab, Executive Vice President, ND Pharmacists Association, testified in favor, responded to many committee questions, and submitted testimony #44787.

3:49 p.m. John Arnold, ND Deputy Insurance Commissioner, submitted neutral testimony and responded to many committee questions.

3:57 p.m. Megan Hruby, representing Blue Cross Blue Shield, testified in opposition to HB 1584.

4:06 p.m. William Kalanek, Pharmaceutical Care Management Association, testified in opposition and submitted testimony #44778.

4:09 p.m. Mark Hardy, Executive Director, ND Pharmacy Board, submitted neutral testimony.

4:36 p.m. Chairman Wanzek closed the hearing.

Carol Thompson, Committee Clerk

As representatives of the North Dakota business community, we are writing on behalf of employers who rely on the Employee Retirement Income Security Act (ERISA) to provide high-quality health benefits to North Dakotans. We urge you to protect this vital law, which has safeguarded both employees and employers for over 50 years.

When ERISA was passed by Congress in 1974, it preempted states from passing laws affecting the administration or design of employer health plans. This important preemption has remained intact for over 50 years, providing a consistent regulatory framework that allows employers to operate confidently across state lines, minimizing the administrative burdens that would otherwise come with a patchwork of state-level regulations.

- **ERISA protects the State of North Dakota and taxpayers** by encouraging private employers to offer benefit plans for their employees rather than relying on public resources.
- **ERISA protects employees** by establishing consistent guidelines for retirement and health plans offered by multi-state private employers.
- **ERISA protects employers** by supporting a uniform benefit program for all employees and by avoiding complications of a patchwork system between states.

In North Dakota, close to 430,000 people rely on ERISA-regulated self-funded health plans. These plans are the backbone of our state's health care coverage. ERISA's uniformity is essential to North Dakota's economic success, enabling businesses to offer competitive benefits and maintain operational efficiency without the complexities of varying state mandates. For small and medium-sized businesses in particular, ERISA's protections are crucial for providing affordable and consistent benefits across their workforce.

Unfortunately, recent legislative efforts have sought to circumvent ERISA's protections by imposing state-level healthcare mandates on employers. These efforts risk significantly increasing healthcare costs for North Dakota employers and their employees. Allowing expensive state mandates to interfere with ERISA protections would create a patchwork of conflicting rules, making it harder for businesses to offer consistent, affordable health benefits and weakening North Dakota's ability to attract and retain businesses.

It is also important to note that during this session, efforts to pierce ERISA by extending state healthcare mandates to ERISA-regulated plans should receive little support from those who want to keep North Dakota economically competitive. Key proposals, such as HB 1584, if enacted, will lead to an explosion of healthcare costs for North Dakota's businesses. **Even in its amended form, the language of HB 1584 may apply any existing and future state anti-payor laws to health plans organized under federal ERISA law.** We hope the Legislature will not advance HB 1584 and recognize the crucial role these protections play in allowing businesses to offer consistent, affordable benefits to employees.

This session, preserving ERISA is a top priority for the North Dakota business community. Rising healthcare costs only further emphasize the need to maintain ERISA's uniform standards, which have helped businesses manage expenses and remain competitive in national and global markets. Indeed, businesses in North Dakota often rank controlling employee healthcare costs as a major concern. Additional state mandates would not only increase compliance costs but could also discourage businesses from expanding their operations in North Dakota, jeopardizing the economic growth that has helped North Dakota attract innovation and investment in recent years.

We respectfully ask that you stand with the business community to protect this landmark law and **VOTE NO on HB 1584**. By doing so, we can safeguard the long-term success of North Dakota businesses, support the health and well-being of our workforce, and ensure that North Dakota remains a leading destination for innovation, investment, and job creation.

Thank you for your attention to this critical issue. The North Dakota business community stands ready to collaborate on solutions that ensure a strong future for both businesses and workers

AHIP
Lignite Energy Council
PCMA
GNDC Greater North Dakota Chamber
BASIN ELECTRIC POWER COOPERATIVE A Touchstone Energy® Cooperative
ONEOK
ConocoPhillips
Power Companies of North Dakota
North Dakota Petroleum Council
ICBND Independent Community Banks of North Dakota
NDARECs North Dakota Association of Rural Electric Cooperatives Your Touchstone Energy® Cooperative
HESS
North Dakota Bankers Association
MDU Resources Group, Inc.

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Senate Government Operations Appropriations Committee
HB 1584 – 4/8/25 – 3:00pm
Senator Wanzek – Chairman

Chairman Wanzek and members of the committee, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1584.

HB 1584 looks to address a legal concern, changes to the marketplace and how can North Dakota create a process for implementing and enforcing already existing PBM laws. There has been a lot of good discussion in both policy committees who have heard and passed this bill. We anticipated most of the discussion would center around the appropriation side of the bill which is why we are here today.

Chairman and members of the committee, licensing and providing a pathway for enforcing PBM laws has been talked about in the past, including during interim hearings. There is one common theme around the country, there is bipartisan support to pass PBM reforms and action to enforce PBM laws. There is a lot of movement at the Federal Trade Commission, Congressional hearings, many reports and investigations centered around the anticompetitive behavior of PBMs, patient steering, lack of transparency, spread pricing and many transactions taken place that benefit the PBM over patients, employers, government entities and taxpayers.

This legislative assembly has a long history of passing PBM reform and transparency laws by an overwhelming majority in both Chambers. To-date, ND continues to punt on any meaningful oversight and enforcement of our PBMs laws. HB 1584 looks to finally bring a formal process for licensure, oversight and enforcement of our existing PBM laws.

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I would like to highlight some of the issues going on in the PBM market around the country and specifically in ND. Here are 3 press releases from the Federal Trade Commission regarding their recent reports and findings on PBMs. One was released in 2024 and another one in 2025.

FTC Recent Press Releases:
https://www.ftc.gov/reports/pharmacy-benefit-managers-report

https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen

https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices

I have also included a link to the U.S. House Oversight and Accountability Committee which has held numerous PBM hearings in the past couple of years. Chairman Comer (R-KY) issued a rather telling report in 2024. His committee also issued letters to the 3 main PBMs who testified giving them a deadline to correct their statements in front of his committee.

Comer Releases Report on PBMs' Harmful Pricing Tactics and Role in Rising Health Care Costs - United States House Committee on Oversight and Accountability

What has been happening in other states around the country? Below I provided a few highlights regarding what other states are finding when looking into PBM practices.

Ohio: the state Auditor found that, PBMs pocketed $224.8 million through the spread alone during a one-year period.

Kentucky: In response to a state report that found PBMs keep $123.5 million in spread annually, the Attorney General has launched an investigation into allegations that the PBMs have overcharged the state and discriminated against independent pharmacies.

Michigan: Drug price manipulation allowed PBMs to overcharge Michigan Medicaid by at least $64 million.

Virginia: A state-commissioned report on Medicaid found PBMs pocket $29 million in spread pricing alone.

Maryland: A state Medicaid report found PBMs pocket $72 million annually in spread pricing alone.

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Florida: A report found PBMs steer patients to PBM-affiliated pharmacies, and "when it comes to dispensing brand name drugs, MCO/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."

Illinois: An audit found $200 million of spread pricing in 2021-2022.

Oregon: A 2023 audit found insufficient transparency and compliance with highly inconsistent reimbursement, including twice as much reimbursement to PBM-owned pharmacies than to independent pharmacies for selected drugs.

Below are a few more recent links regarding PBM issues in the market.

https://www.fox9.com/news/prime-therapeutics-ordered-pay-10-million-price-fixing

https://www.fox9.com/news/prescription-drug-prices-marked-up-high-5000-investigation-finds

Ohio - AG Yost secures $49.1 Million settlement in price-fixing cases involving generic drugs | News from WLIO | hometownstations.com

PBMs are modern-day drug price gangsters and must be held accountable • Ohio Capital Journal

https://www.ajmc.com/view/goodrx-pbms-hit-by-price-fixing-lawsuits

What has happened or is happening in ND related to PBM issues? In 2019, there were a number of discrepancies and questions around Medicaid Expansion being run as managed care by one of the big 3 PBMs. After gathering additional information and verification, the ND Department of HHS turned things over to the Medicaid Fraud Unit. As a result, this legislative assembly decided to remove the PBM from Medicaid Expansion and moved it in-house with traditional Medicaid. The state of ND saved $17 million dollars by removing the PBM from administering the prescription drug benefit for Medicaid Expansion.

Following what happened in ND Medicaid Expansion, this legislative assembly decided to pass a bill to audit the ND Public Employees Retirement System (NDPERS). What happened with that audit? See for yourself. The PBM decided it was not going to cooperate and elected to provide the ND State Auditor with basically no information. I provided the press release from the State Auditor's

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office showing there were 5 findings during the audit. Each of the findings had to do with the PBM refusing to provide the requested and necessary information to complete the audit.

PBM Refuses to Provide Requested Data to State Auditor

Prescription Benefits Manager Optum Rx Refuses to Provide Requested Data to State Auditor's Office | State Auditor's Office

This legislative assembly has passed a number of PBM reform laws of the past decade or so. Those provisions benefit employers, patients, pharmacies, taxpayers and government entities but we have no formal process for accountability, oversight or enforcement in ND. HB 1584 looks to finally hold PBMs accountable in ND.

Section 1 - Page 3 – Lines 11-14

This language establishes the initial application fee for PBMs under the Insurance Commissioner.

Section 2 – Page 3 – Lines 31 through page 4 – Lines 1-7

This language is removed and provides a continued appropriation to the Insurance Commissioner's office. I understand the continued appropriation is not well received and I can appreciate such. I think we can work to address this concern and I hope with the help of this committee we do just that.

Page 4 – Lines 12-23

Definition is changed to address a legal concern and is based off of past court decisions. At the request of both the House and Senate Industry and Business committee Chairs, the former Special Assistant Attorney General for ND testified as to why the changes are needed. Robert Smith was hired by ND to defend the PBM laws this legislative assembly passed in 2017. Mr. Smith and the ND AG's office went all the way to the Supreme Court of the U.S. and prevailed. Mr. Smith has also represented all the major ERISA cases over the past decade including the Rutledge decision versus PCMA (PBMs) in front of the Supreme Court of the U.S, which he also won.

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Page 5 – Lines 9-11

Language is added to include rebate aggregators. What is a rebate aggregator? A rebate aggregator is often owned by the PBM or affiliated with the PBM. Two of the three main rebate aggregators are located outside the United States with one being Ireland and the other in Switzerland. We feel most of the rebate model has shifted in favor of rebate aggregators. If we are asking for information on rebates, it is important to gather information on rebate aggregators since the Big 3 PBMs now own them. Rebate aggregators have a negative effect on the rebates that employer plans should be receiving. Through these overseas companies, PBMs are able to maximize rebate retention for the benefit of the PBM and not the plans or patients. Rebate aggregators retain a portion of the rebate amount as fees. PBMs also reclassify rebates as administrative fees through this process. It is not uncommon to see higher cost drugs with higher rebates prioritized on formularies over better value or lower costs. You will also find contract language that excludes rebates when drugs are filled by a PBM owned pharmacy, mail order or specialty mail order pharmacy.

Plan Sponsor ALERT: Beware of Rebate Aggregators

FTC Expands PBM Investigation to PBM-Owned Rebate Aggregators/GPOs

Language is also added to verify how much of the rebate dollars were retained by the PBM.

Page 5 – Lines 15-16

Since this law was enacted, we have seen a lot of market changes, especially around fees pharmacies pay to PBMs. From 2010 to 2020, PBM fees charged to pharmacies increased 91,000%! That is not a typo. We would like to see other price concessions or financial payments that are paid by the pharmacy to the PBM also be reported.

According to the fiscal year 2022 budget justification (p.242) estimate sent to Congress by CMS, pharmacy DIR fees increased by 91,500 percent between 2010 and 2019. For context, a $4 gallon of milk increased by that much would cost $3,660. (NCPA).

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Page 5 – Lines 30 through page 6 – Lines 1- 7

We support changing the definition of pharmacy benefits manager as amended in the House to reflect a concern brought by some employers. By making this change, we can avoid or lessen concerns around ERISA preemption. This amendment was suggested by Mr. Robert Smith the expert ERISA attorney the State of ND hired to defend our PBM reform laws.

Section 4 – Page 6 – Lines 16-31 and Page 7 – Lines 1-15

This section provides for a formal process for licensing PBMs in North Dakota. This section also establishes the condition, terms, fees and application process to bring oversight under the ND Insurance Commissioner's office. This section was offered by the ND Insurance Commissioner's office as an amendment in the House which the House added to the bill to formalize the process for oversight of PBMs in ND. The ND Insurance Commissioner's office is the best place for authority over PBM practices and is considered a best practice for enforcement of state PBM laws. By having authority under the ND Insurance Commissioner's office, we are able to use the state policing powers and insurance savings clause protections.

Page 7 – Lines 19-22

Twenty years ago, when this law was passed, the "substitution of one prescription drug for another" was really the only other PBM related law under 19-02.1, Since the passage of that law, the ND Legislative Assembly has passed a number of other PBM reforms and they are placed under 19-02.1. HB 1584 would help bring the rest of the PBM laws in 19-02.1 under enforcement of the Insurance Commissioner.

Page 7 – Lines 29-31

HB 1584 adds two more provisions dealing with PBM contracting practices. In recent years, the PBMs have started to offer "silent agreement" contracts. They basically send out a fax or email

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and state "if we do not hear from you in the next 14 days, the pharmacy will automatically agree to the terms and conditions." HB 1584 looks to add language that requires a signature from the pharmacy and PBM before a contract is finalized and agreed upon.

Page 8 – Lines 1-2

HB 1584 also looks to provide the ability of a pharmacy to opt-out of a PBM contract giving a 90-day notice. We are seeing PBMs trying to lock pharmacies into multi-year contracts with no reasonable opt-out structure. PBMs can drop a pharmacy from the network with little to no notice, so we feel it is fair that pharmacies are given a more reasonable way to opt-out of a PBM contract. Providing a 90-day notice should be a reasonable request.

Sections 8 and 9 - Enforcement and Penalties

These sections would establish not only an enforcement pathway but provide some expertise and help to the insurance commissioner's office. There are a number of states that have placed PBM enforcement with their Insurance Commissioner. Maybe I am wrong, but I assume the ND Insurance Commissioner, Board of Pharmacy and ND Health & Human Services could enter into a meaningful agreement(s) to help ease the workload and help provide additional expertise. Depending on what the agreement(s) looks like, the Board of Pharmacy could help with fielding complaints, fact finding, hearings, etc. and then turn things over to the Insurance Commissioner for final review and any potential enforcement. The penalties section is self-explanatory and should help with PBM compliance.

Section 10

This section deals with the proceedings by the commissioner and service of process procedures.

Section 11

This section deals with funding provided by the ND Board of Pharmacy to the Insurance Commissioner's office.

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Section 12

This section repeals a definition and a section of law that deals with the Drug Pricing Fund that was established in 2021 and has been implemented and not needed according to the Insurance Commissioner's office. There is roughly $1.6 million dollars in this fund currently.

Section 13

This section allows the insurance commissioner the ability to hire employees for the implementation of HB 1584. It is time limited and only for the coming biennium. He also can only hire individuals for purposes of enforcing chapter 26. 1-27.1. The commissioner must also report to OMB and legislative council any adjustments made.

Section 14

This provides a transfer of the balance sitting in the drug pricing fund to the insurance regulator trust fund.

In conclusion, HB 1584 (1) cleans up language from twenty years ago, (2) removes language to help withstand legal concerns, (3) adds a couple of PBM reforms laws to address market changes, (4) provides a pathway for enforcement and (5) helps streamline enforcement efforts while attempting to help provide expertise to the Insurance Commissioner's office. We truly hope we can look at how to make this work for the patients, employers, taxpayers and many others in ND.

Thank you for your time and attention today. I am happy to try and answer any questions.

Respectfully Submitted,

Mike Schwab

NDPhA - EVP

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Government Operations Division
Red River Room, State Capitol

HB 1584
4/9/2025

A BILL for an Act to create and enact four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-01-07.1, 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide a continuing appropriation; to provide a transfer; to provide an effective date; and to declare an emergency.

11:12 a.m. Chairman Wanzek opened the meeting.

Members present: Chairman Wanzek, Vice-Chair Dwyer, Senator Burckhard, Senator Erbele, and Senator Sickler.

Discussion Topics:

- Potential separate fund to regulate PBMs
- Fees charged to PBMs and placed in new fund
- Insurance Regulatory Trust Fund reserve balance proposal
- Licensure for wholesale drug sales
- Exemption of self-funded insurance
- Employee Retirement Income Security Act (ERISA) exemption
- Potential of increased cost of operations and increased premiums
- Federal regulatory policy
- Copays and cost of medications
- Actuarial analysis
- New full-time employees (FTEs) and costs for regulation
- Attorney General litigation pool eligibility for Insurance Department

11:18 Brady Larson, Assistant Legislative Budget Analyst, responded to a committee Question.

11:19 a.m. John Arnold, Deputy ND Insurance Commissioner, responded to committee questions.

11:24 a.m. Mark Hardy, Executive Director, ND Pharmacy Board answered committee questions.

11:30 a.m. William Kalanek, Pharmaceutical Care Management Association, responded to committee questions.

11:36 a.m. Mike Schwab, Executive Vice President, ND Pharmacists Association, addressed committee questions

11:40 a.m. Jon Godfread, ND Insurance Commissioner, submitted neutral testimony.

11:44 a.m. Chairman Wanzek closed the meeting.

Carol Thompson, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Government Operations Division
Red River Room, State Capitol

HB 1584
4/10/2025

A BILL for an Act to create and enact four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-01-07.1, 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide a continuing appropriation; to provide a transfer; to provide an effective date; and to declare an emergency.

3:15 p.m. Chairman Wanzek opened the hearing.

Members present: Chairman Wanzek, Vice-Chair Dwyer, Senator Burckhard, Senator Erbele, and Senator Sickler.

Discussion Topics:

- Fiscal and policy aspects of the bill
- Pharmacy benefit manager enforcement fund
- Fees for program services
- Required actuarial analysis of effects of policies in this bill

3:16 p.m. Adam Mathiak, LC Senior Fiscal Analyst, distributed testimony #44912, the proposed amendments.

3:18 p.m. Senator Sickler introduced the proposed amendments for HB 1584 for committee discussion.

3:24 p.m. Senator Sickler moved to Adopt the Amendments, 25.1281.02005, for HB 1584.
3:24 p.m. Senator Erbele seconded the motion.

Senators	Vote
Senator Terry M. Wanzek	Y
Senator Randy A. Burckhard	Y
Senator Michael Dwyer	Y
Senator Robert Erbele	Y
Senator Jonathan Sickler	Y

Motion passed 5-0-0.

3:25 p.m. Senator Sickler moved a Do Pass as Amended for HB 1584.
3:25 p.m. Senator Erbele seconded the motion.

Senators	Vote
Senator Terry M. Wanzek	Y
Senator Randy A. Burckhard	Y
Senator Michael Dwyer	Y
Senator Robert Erbele	Y
Senator Jonathan Sickler	Y

Motion passed 5-0-0.

Senator Sickler will carry this bill.

3:30 p.m. Chairman Wanzek closed the meeting.

Carol Thompson, Committee Clerk

25.1281.02005
Title.

Prepared by the Legislative Council staff for Senator Sickler
April 10, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1584

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

In place of the amendments (25.1281.02003) adopted by the Senate, Engrossed House Bill No. 1584 is amended by amendment (25.1281.02005) as follows:

A BILL for an Act to create and enact ~~two~~four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers and a pharmacy benefit manager enforcement fund; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide an appropriation; to provide for a transfer; to provide an effective date; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-01-07 of the North Dakota Century Code is amended and reenacted as follows:

1. The commissioner shall charge and collect the following fees:
   a. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.
   b. For each original certificate of authority issued upon admittance and for each annual renewal thereof, one hundred dollars and for amendment to certificate of authority, or certified copy thereof, fifty dollars.
   c. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

d. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, one hundred dollars.

e. For filing of articles of merger, or copies thereof, thirty dollars.

f. For filing an annual statement, twenty-five dollars.

g. For filing the abstract of the annual statement of an insurance company for publication, thirty dollars.

h. For an official examination, the expenses of the examination at the rate adopted by the department. The rates must be reasonably related to the direct and indirect costs of the examination, including actual travel expenses, including hotel and other living expenses, compensation of the examiner and other persons making the examination, and necessary attendant administrative costs of the department directly related to the examination and must be paid by the examined insurer together with compensation upon presentation by the department to the insurer of a detailed account of the charges and expenses after a detailed statement has been filed by the examiner and approved by the department.

i. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits and for any renewal of the certificate, twenty-five dollars.

j. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which must be paid to the testing service.

k. For issuing a surplus lines insurance producer's or insurance consultant's license, one hundred dollars. For each annual renewal of a surplus lines insurance producer's or insurance consultant's license, twenty-five dollars.

l. For issuing an insurance producer's license, one hundred dollars.

m. For issuing a duplicate of any license or registration issued under this title, ten dollars.

n. For each insurance company appointment and renewal of an appointment of an insurance producer, ten dollars.

o. For each company application for admission, five hundred dollars, except applications for admission for county mutual, fraternal benefit, and surplus lines companies must be one hundred dollars.

p. For issuing a license and each annual renewal of a license to an insurance premium finance company, one hundred dollars.

q. For examining or investigating an insurance premium finance company, the actual expense and per diem incurred; but the per diem charge may not exceed fifty dollars.

r. For issuing and each annual renewal of a license to an advisory organization, fifty dollars.

s. For filing an individual insurance producer licensing continuation, twenty-five dollars.

t. For services provided by the state fire marshal.

u. For the initial application fee for a pharmacy benefit manager, an amount determined by the commissioner, which may not exceed ten thousand dollars. For each annual renewal, an amount to be determined by the commissioner, which may not exceed ten thousand dollars.

SECTION 2. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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~~policies or ~~contract~~contracts that do not include prescription drug coverage.

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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee~~;~~, pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. 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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 3. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from the the commissioner under ~~to~~ this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website ~~that~~which includes a request for the following information:
   a. The identity, address, electronic mail address, and telephone number of the applicant;
   b. The name, business address, electronic mail address, and telephone number of the contact person for the applicant;
   c. If applicable, the federal employer identification number for the applicant; and
   d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.
3. The term of licensure is one year from April thirtieth through March thirty-first.
4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.
5. ~~The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars.~~ The applicant shall submit the fee with ~~an~~the initial application or renewal application for ~~registration~~licensure. ~~An~~The initial application fee ~~is~~and renewal fee are nonrefundable. ~~The commissioner shall return a renewal application fee if the renewal of registration is not granted.~~
6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.
7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each ~~applicant~~application and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 4. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with subsections 19-02.1-01, 19-02.1-02, 19-02.1-14.2, 19-02.1-16, 19-02.1-16.1, 19-02.1-16.2, 19-02.1-16.3, 19-02.1-16.4, 19-02.1-16.5, and 19-02.1-16.6 in chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.
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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.
3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or ~~entities~~an entity contracting on behalf of ~~pharmacies~~the pharmacy.
4. A pharmacy ~~must be allowed to~~may opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 5. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

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

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received ~~from the pharmacy benefits manager~~ has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager

received under any contract ~~with a pharmacy benefits manager~~ and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 6. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~for ~~implementation of~~to implement this chapter.

SECTION 7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.

2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities, pharmacies, or individuals for losses incurred as a result of the violation.

3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 9. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Proceedings by commissioner - Service of process - Procedure.

The commissioner shall serve process upon any licensee in any action or proceeding instituted by the commissioner under this chapter by electronic mail to the electronic mail address maintained in section 26.1-27.1-02 or by United States mail to the licensee at the licensee's last-known address of record or principal place of business. Service of process under this section is complete upon electronic mailing or United States mailing.

SECTION 10. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Pharmacy benefit manager enforcement fund - State board of pharmacy wholesaler and virtual wholesaler license fees - Revenue deposits or transfers.

The pharmacy benefit manager enforcement fund is a special fund in the state treasury. The fund consists of moneys transferred to or deposited in the fund by legislative action and moneys transferred to or deposited in the fund by the state board of pharmacy. The state board of pharmacy may deposit or transfer up to six hundred dollars of every eligible wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the pharmacy benefit manager enforcement fund. Moneys in the fund are available to the insurance commissioner, subject to legislative appropriations, for enforcing the provisions of this chapter.

SECTION 11. REPEAL. Section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code are repealed.

SECTION 12. TRANSFER - DRUG PRICING FUND TO PHARMACY BENEFIT MANAGER ENFORCEMENT FUND. On the effective date of this Act, the office of management and budget shall transfer the balance in the drug pricing fund to the pharmacy benefit manager enforcement fund for the purpose of enforcing the provisions of chapter 26.1-27.1.

SECTION 13. APPROPRIATION. There is appropriated out of any moneys in the pharmacy benefit manager enforcement fund in the state treasury, not otherwise appropriated, the sum of $1,200,000, or so much of the sum as may be necessary, to the insurance commissioner for the purpose of enforcing the provisions of chapter 26.1-27-1 and conducting an actuarial analysis of the effect of the policies contained in this Act on health insurance premiums and consumer drug prices, for the period beginning with the effective date of this Act and ending June 30, 2027. The insurance commissioner is authorized three full-time equivalent positions, including an attorney, a pharmacist, and an investigator, for this purpose.

SECTION 14. EFFECTIVE DATE. Section 3 of this Act becomes effective January 1, 2026.

SECTION 15. EXPIRATION DATE. Section 10 of this Act is effective through June 30, 2029, and after that date is ineffective.

SECTION 16. EMERGENCY. This Act is declared to be an emergency measure.

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1584
4/14/2025

Relating to pharmacy benefits managers, pharmacy benefits managers, pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide a continuing appropriation; to provide a transfer; to provide an effective date; and to declare an emergency.

8:08 a.m. Chairman Bekkedahl called the meeting to order.

Members Present: Chairman Bekkedahl, Vice-Chairman Erbele, and Senators Burckhard, Cleary, Conley, Davison, Dever, Dwyer, Magrum, Mathern, Meyer, Schaible, Sickler, Sorvaag, Thomas, Wanzek.

Discussion Topics:

- Administrative Penalties and Enforcement
- Prescription Prices
- Pharmacy Freedoms
- Independent Pharmacies Feedback

8:09 a.m. Senator Dwyer introduced the bill and submitted testimony #44958.

8:14 a.m. Senator Dwyer moved amendment LC 25.1281.02005.

8:14 a.m. Senator Wanzek seconded the motion.

Senators	Vote
Senator Brad Bekkedahl	Y
Senator Robert Erbele	Y
Senator Randy A. Burckhard	Y
Senator Sean Cleary	Y
Senator Cole Conley	Y
Senator Kyle Davison	Y
Senator Dick Dever	Y
Senator Michael Dwyer	Y
Senator Jeffery J. Magrum	Y
Senator Tim Mathern	Y
Senator Scott Meyer	Y
Senator Donald Schaible	Y
Senator Jonathan Sickler	Y
Senator Ronald Sorvaag	Y
Senator Paul J. Thomas	Y
Senator Terry M. Wanzek	Y

Motion Passed 16-0-0.

8:23 a.m. Senator Dwyer moved a Do Pass as Amended.

8:23 a.m. Senator Wanzek seconded the motion.

Senators	Vote
Senator Brad Bekkedahl	Y
Senator Robert Erbele	Y
Senator Randy A. Burckhard	Y
Senator Sean Cleary	Y
Senator Cole Conley	Y
Senator Kyle Davison	Y
Senator Dick Dever	Y
Senator Michael Dwyer	Y
Senator Jeffery J. Magrum	Y
Senator Tim Mathern	Y
Senator Scott Meyer	Y
Senator Donald Schaible	Y
Senator Jonathan Sickler	Y
Senator Ronald Sorvaag	Y
Senator Paul J. Thomas	N
Senator Terry M. Wanzek	Y

Motion Passed 15-1-0.

Senator Dwyer will carry the bill.

8:25 a.m. Chairman Bekkedahl closed the hearing.

Elizabeth Reiten, Committee Clerk

25.1281.02005
Title.04000

Prepared by the Legislative Council staff for Senator Sickler
April 10, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

VC 4/14/25
1 of 10

ENGROSSED HOUSE BILL NO. 1584

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

In place of the amendments (25.1281.02003) adopted by the Senate, Engrossed House Bill No. 1584 is amended by amendment (25.1281.02005) as follows:

A BILL for an Act to create and enact ~~two~~four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers and a pharmacy benefit manager enforcement fund; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide an appropriation; to provide for a transfer; to provide an effective date; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-01-07 of the North Dakota Century Code is amended and reenacted as follows:

1. The commissioner shall charge and collect the following fees:
   a. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.
   b. For each original certificate of authority issued upon admittance and for each annual renewal thereof, one hundred dollars and for amendment to certificate of authority, or certified copy thereof, fifty dollars.
   c. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

d. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, one hundred dollars.

e. For filing of articles of merger, or copies thereof, thirty dollars.

f. For filing an annual statement, twenty-five dollars.

g. For filing the abstract of the annual statement of an insurance company for publication, thirty dollars.

h. For an official examination, the expenses of the examination at the rate adopted by the department. The rates must be reasonably related to the direct and indirect costs of the examination, including actual travel expenses, including hotel and other living expenses, compensation of the examiner and other persons making the examination, and necessary attendant administrative costs of the department directly related to the examination and must be paid by the examined insurer together with compensation upon presentation by the department to the insurer of a detailed account of the charges and expenses after a detailed statement has been filed by the examiner and approved by the department.

i. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits and for any renewal of the certificate, twenty-five dollars.

j. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which must be paid to the testing service.

k. For issuing a surplus lines insurance producer's or insurance consultant's license, one hundred dollars. For each annual renewal of a surplus lines insurance producer's or insurance consultant's license, twenty-five dollars.

l. For issuing an insurance producer's license, one hundred dollars.

m. For issuing a duplicate of any license or registration issued under this title, ten dollars.

n. For each insurance company appointment and renewal of an appointment of an insurance producer, ten dollars.

o. For each company application for admission, five hundred dollars, except applications for admission for county mutual, fraternal benefit, and surplus lines companies must be one hundred dollars.

p. For issuing a license and each annual renewal of a license to an insurance premium finance company, one hundred dollars.

q. For examining or investigating an insurance premium finance company, the actual expense and per diem incurred; but the per diem charge may not exceed fifty dollars.

r. For issuing and each annual renewal of a license to an advisory organization, fifty dollars.

s. For filing an individual insurance producer licensing continuation, twenty-five dollars.

t. For services provided by the state fire marshal.

u. For the initial application fee for a pharmacy benefit manager, an amount determined by the commissioner, which may not exceed ten thousand dollars. For each annual renewal, an amount to be determined by the commissioner, which may not exceed ten thousand dollars.

SECTION 2. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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~~policies or ~~contract~~contracts that do not include prescription drug coverage.

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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee~~;~~, pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity~~. ~~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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 3. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from ~~the~~ the commissioner under ~~to~~ this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website ~~that~~which includes a request for the following information:
   a. The identity, address, electronic mail address, and telephone number of the applicant;
   b. The name, business address, electronic mail address, and telephone number of the contact person for the applicant;
   c. If applicable, the federal employer identification number for the applicant; and
   d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.
3. The term of licensure is one year from April thirtieth through March thirty-first.
4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.
5. ~~The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars.~~ The applicant shall submit the fee with ~~an~~the initial application or renewal application for ~~registration~~licensure. ~~An~~The initial application fee ~~is~~and renewal fee are nonrefundable. ~~The commissioner shall return a renewal application fee if the renewal of registration is not granted.~~
6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.
7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each ~~applicant~~application and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 4. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with sections 19-02.1-01, 19-02.1-02, 19-02.1-14.2, 19-02.1-16, 19-02.1-16.1, 19-02.1-16.2, 19-02.1-16.3, 19-02.1-16.4, 19-02.1-16.5, and 19-02.1-16.6 in chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.
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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.
3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or ~~entities~~an entity contracting on behalf of ~~pharmacies~~the pharmacy.
4. A pharmacy ~~must be allowed to~~may opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 5. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

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

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received ~~from the pharmacy benefits manager~~ has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager

received under any contract ~~with a pharmacy benefits manager~~ and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 6. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~~~for implementation of~~to implement this chapter.

SECTION 7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.

2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities, pharmacies, or individuals for losses incurred as a result of the violation.

3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 9. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Proceedings by commissioner - Service of process - Procedure.

The commissioner shall serve process upon any licensee in any action or proceeding instituted by the commissioner under this chapter by electronic mail to the electronic mail address maintained in section 26.1-27.1-02 or by United States mail to the licensee at the licensee's last-known address of record or principal place of business. Service of process under this section is complete upon electronic mailing or United States mailing.

SECTION 10. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Pharmacy benefit manager enforcement fund - State board of pharmacy wholesaler and virtual wholesaler license fees - Revenue deposits or transfers.

The pharmacy benefit manager enforcement fund is a special fund in the state treasury. The fund consists of moneys transferred to or deposited in the fund by legislative action and moneys transferred to or deposited in the fund by the state board of pharmacy. The state board of pharmacy may deposit or transfer up to six hundred dollars of every eligible wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the pharmacy benefit manager enforcement fund. Moneys in the fund are available to the insurance commissioner, subject to legislative appropriations, for enforcing the provisions of this chapter.

SECTION 11. REPEAL. Section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code are repealed.

SECTION 12. TRANSFER - DRUG PRICING FUND TO PHARMACY BENEFIT MANAGER ENFORCEMENT FUND. On the effective date of this Act, the office of management and budget shall transfer the balance in the drug pricing fund to the pharmacy benefit manager enforcement fund for the purpose of enforcing the provisions of chapter 26.1-27.1.

SECTION 13. APPROPRIATION - INSURANCE COMMISSIONER - PHARMACY BENEFIT MANAGER ENFORCEMENT FUND. There is appropriated out of any moneys in the pharmacy benefit manager enforcement fund in the state treasury, not otherwise appropriated, the sum of $1,200,000, or so much of the sum as may be necessary, to the insurance commissioner for the purpose of enforcing the provisions of chapter 26.1-27.1 and conducting an actuarial analysis of the effect of the policies contained in this Act on health insurance premiums and consumer drug prices, for the period beginning with the effective date of this Act and ending June 30, 2027. The insurance commissioner is authorized three full-time equivalent positions, including an attorney, a pharmacist, and an investigator, for this purpose.

SECTION 14. EFFECTIVE DATE. Section 3 of this Act becomes effective on January 1, 2026.

SECTION 15. EXPIRATION DATE. Section 10 of this Act is effective through June 30, 2029, and after that date is ineffective.

SECTION 16. EMERGENCY. This Act is declared to be an emergency measure.

REPORT OF STANDING COMMITTEE
ENGROSSED AND AMENDED HB 1584

Appropriations Committee (Sen. Bekkedahl, Chairman) recommends **AMENDMENTS (25.1281.02005)** and when so amended, recommends **DO PASS** (15 YEAS, 1 NAY, 0 ABSENT OR EXCUSED AND NOT VOTING). Engrossed HB 1584, as amended, was placed on the Sixth order on the calendar. This bill does not affect workforce development.

25.1281.02005
Title.

Prepared by the Legislative Council staff for Senator Sickler
April 10, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1584

Introduced by

Representatives Kasper, Koppelman, Lefor, Steiner, Vigesaa, Warrey

Senators Barta, Boehm, Boschee, Hogue, Klein

In place of the amendments (25.1281.02003) adopted by the Senate, Engrossed House Bill No. 1584 is amended by amendment (25.1281.02005) as follows:

A BILL for an Act to create and enact ~~two~~four new sections to chapter 26.1-27.1 of the North Dakota Century Code, relating to pharmacy benefits managers and a pharmacy benefit manager enforcement fund; to amend and reenact subsection 1 of section 26.1-01-07, sections 26.1-27.1-01, 26.1-27.1-02, 26.1-27.1-04, 26.1-27.1-06 and 26.1-27.1-07 of the North Dakota Century Code, relating to pharmacy benefits managers; to repeal section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code, relating to pharmacy benefits managers and prescription drug costs; to provide a penalty; to provide an appropriation; to provide for a transfer; to provide an effective date; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-01-07 of the North Dakota Century Code is amended and reenacted as follows:

1. The commissioner shall charge and collect the following fees:
   a. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.
   b. For each original certificate of authority issued upon admittance and for each annual renewal thereof, one hundred dollars and for amendment to certificate of authority, or certified copy thereof, fifty dollars.
   c. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

d. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, one hundred dollars.

e. For filing of articles of merger, or copies thereof, thirty dollars.

f. For filing an annual statement, twenty-five dollars.

g. For filing the abstract of the annual statement of an insurance company for publication, thirty dollars.

h. For an official examination, the expenses of the examination at the rate adopted by the department. The rates must be reasonably related to the direct and indirect costs of the examination, including actual travel expenses, including hotel and other living expenses, compensation of the examiner and other persons making the examination, and necessary attendant administrative costs of the department directly related to the examination and must be paid by the examined insurer together with compensation upon presentation by the department to the insurer of a detailed account of the charges and expenses after a detailed statement has been filed by the examiner and approved by the department.

i. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits and for any renewal of the certificate, twenty-five dollars.

j. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which must be paid to the testing service.

k. For issuing a surplus lines insurance producer's or insurance consultant's license, one hundred dollars. For each annual renewal of a surplus lines insurance producer's or insurance consultant's license, twenty-five dollars.

l. For issuing an insurance producer's license, one hundred dollars.

m. For issuing a duplicate of any license or registration issued under this title, ten dollars.

n. For each insurance company appointment and renewal of an appointment of an insurance producer, ten dollars.

o. For each company application for admission, five hundred dollars, except applications for admission for county mutual, fraternal benefit, and surplus lines companies must be one hundred dollars.

p. For issuing a license and each annual renewal of a license to an insurance premium finance company, one hundred dollars.

q. For examining or investigating an insurance premium finance company, the actual expense and per diem incurred; but the per diem charge may not exceed fifty dollars.

r. For issuing and each annual renewal of a license to an advisory organization, fifty dollars.

s. For filing an individual insurance producer licensing continuation, twenty-five dollars.

t. For services provided by the state fire marshal.

u. For the initial application fee for a pharmacy benefit manager, an amount determined by the commissioner, which may not exceed ten thousand dollars. For each annual renewal, an amount to be determined by the commissioner, which may not exceed ten thousand dollars.

SECTION 2. AMENDMENT. Section 26.1-27.1-01 of the North Dakota Century Code is amended and reenacted 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~~policies or ~~contract~~contracts that do not include prescription drug coverage.

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.~~5. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:

a. A rebate collected by the pharmacy benefits manager or a rebate aggregator which is allocated to a covered entity, or retained by the pharmacy benefits manager;

b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;

c. A pharmacy network fee~~;~~, pharmacy price concessions, and any other financial payment made by a pharmacy to a pharmacy benefits manager; and

d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

~~7.~~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. Claims processing, ~~retail~~pharmacy network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;

b. Clinical formulary development and management services; or

c. Rebate contracting and administration.

~~8.~~7. "Pharmacy benefits manager" means a person ~~that~~who performs pharmacy benefits management, as a third party, under a contract or other ~~fincancial~~financial arrangement with a covered entity. The term ~~includes~~does not include a ~~person acting for a~~ health benefit plan that manages or directs its own pharmacy benefits ~~manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. 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.~~

~~9.~~8. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.

~~10.~~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.

SECTION 3. AMENDMENT. Section 26.1-27.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-02. Licensing - Terms and fee - Application.

1. A person may not ~~perform~~establish or ~~act~~operate as a pharmacy benefits manager in this state ~~unless that person holds~~without first obtaining a ~~certificate of registration~~license ~~as an administrator under chapter 26.1-27~~from ~~the~~ the commissioner under ~~to~~ this section. A person violating this subsection is guilty of a class C felony.

2. A person applying for a pharmacy benefits manager license shall submit an application to the commissioner. The commissioner shall make an application form available on its website ~~that~~which includes a request for the following information:
   a. The identity, address, electronic mail address, and telephone number of the applicant;
   b. The name, business address, electronic mail address, and telephone number of the contact person for the applicant;
   c. If applicable, the federal employer identification number for the applicant; and
   d. Any other information the commissioner considers necessary and appropriate to establish the qualifications to receive a license as a pharmacy benefits manager to complete the licensure process.
3. The term of licensure is one year from April thirtieth through March thirty-first.
4. The pharmacy benefits manager shall pay an annual renewal fee no later than April thirtieth.
5. ~~The commissioner shall determine the amount of the initial application fee, which may not exceed two hundred fifty dollars. The commissioner shall determine the amount of the renewal application fee for the registration, which may not exceed one hundred dollars.~~ The applicant shall submit the fee with ~~an~~the initial application or renewal application for ~~registration~~licensure. ~~An~~The initial application fee ~~is~~and renewal fee are nonrefundable. ~~The commissioner shall return a renewal application fee if the renewal of registration is not granted.~~
6. Each application for a license, and subsequent renewal for a license, must be accompanied by evidence of financial responsibility in an amount of one million dollars.
7. Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall review each ~~applicant~~application and issue a license if the applicant is qualified in accordance with the provisions of this section and the rules promulgated by the commissioner under this section. The commissioner may require additional information or submissions from an applicant and may obtain any documents or information reasonably necessary to verify the information contained in the application.

8. The license may be in paper or electronic form. The license is nontransferable, and must prominently list the expiration date.

SECTION 4. AMENDMENT. Section 26.1-27.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with subsections 19-02.1-01, 19-02.1-02, 19-02.1-14.2, 19-02.1-16, 19-02.1-16.1, 19-02.1-16.2, 19-02.1-16.3, 19-02.1-16.4, 19-02.1-16.5, and 19-02.1-16.6 in chapter 19-02.1 ~~regarding the substitution of one prescription drug for another~~.
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 if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.
3. A pharmacy benefits manager shall offer pharmacy contracts that are opt-in contracts with at least thirty days to respond and signatures must be obtained from the pharmacy or ~~entities~~an entity contracting on behalf of ~~pharmacies~~the pharmacy.
4. A pharmacy ~~must be allowed to~~may opt-out of a pharmacy benefits managers contract by providing at least a ninety-day notice.

SECTION 5. AMENDMENT. Section 26.1-27.1-06 of the North Dakota Century Code is amended and reenacted as follows:

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

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received ~~from the pharmacy benefits manager~~ has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager

received under any contract ~~with a pharmacy benefits manager~~ and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.

3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1. This section does not prevent the disclosure of a final order issued against a pharmacy benefits manager. Such order is an open record.

SECTION 6. AMENDMENT. Section 26.1-27.1-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-27.1-07. Rulemaking authority.

The commissioner shall adopt rules as necessary ~~before~~for ~~implementation of~~to implement this chapter.

SECTION 7. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Enforcement.

1. All powers granted to the commissioner under title 26.1 and chapter 28-32 are available in enforcing chapter 26.1-27.1, including subpoena power.
2. This section does not limit the attorney general from investigating and prosecuting violations of the law.
3. This section does not prohibit the commissioner, state board of pharmacy, or department of health and human services from collaborating through joint exercise of common powers agreements.

SECTION 8. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalties.

1. A pharmacy benefits manager found to be in violation of this chapter or any rules adopted under this chapter is subject to:
   a. A monetary penalty of up to ten thousand dollars per violation;
   b. Suspension or revocation of license; and
   c. A civil penalty of up to fifty thousand dollars for a second or subsequent violation.

2. The commissioner may require a pharmacy benefits manager to provide restitution to affected covered entities, pharmacies, or individuals for losses incurred as a result of the violation.

3. A pharmacy benefits manager subject to penalties under this section is entitled to a hearing conducted in accordance with chapter 28-32.

SECTION 9. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Proceedings by commissioner - Service of process - Procedure.

The commissioner shall serve process upon any licensee in any action or proceeding instituted by the commissioner under this chapter by electronic mail to the electronic mail address maintained in section 26.1-27.1-02 or by United States mail to the licensee at the licensee's last-known address of record or principal place of business. Service of process under this section is complete upon electronic mailing or United States mailing.

SECTION 10. A new section to chapter 26.1-27.1 of the North Dakota Century Code is created and enacted as follows:

Pharmacy benefit manager enforcement fund - State board of pharmacy wholesaler and virtual wholesaler license fees - Revenue deposits or transfers.

The pharmacy benefit manager enforcement fund is a special fund in the state treasury. The fund consists of moneys transferred to or deposited in the fund by legislative action and moneys transferred to or deposited in the fund by the state board of pharmacy. The state board of pharmacy may deposit or transfer up to six hundred dollars of every eligible wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the pharmacy benefit manager enforcement fund. Moneys in the fund are available to the insurance commissioner, subject to legislative appropriations, for enforcing the provisions of this chapter.

SECTION 11. REPEAL. Section 26.1-27-01.1 and chapter 26.1-36.10 of the North Dakota Century Code are repealed.

SECTION 12. TRANSFER - DRUG PRICING FUND TO PHARMACY BENEFIT MANAGER ENFORCEMENT FUND. On the effective date of this Act, the office of management and budget shall transfer the balance in the drug pricing fund to the pharmacy benefit manager enforcement fund for the purpose of enforcing the provisions of chapter 26.1-27.1.

SECTION 13. APPROPRIATION. There is appropriated out of any moneys in the pharmacy benefit manager enforcement fund in the state treasury, not otherwise appropriated, the sum of $1,200,000, or so much of the sum as may be necessary, to the insurance commissioner for the purpose of enforcing the provisions of chapter 26.1-27-1 and conducting an actuarial analysis of the effect of the policies contained in this Act on health insurance premiums and consumer drug prices, for the period beginning with the effective date of this Act and ending June 30, 2027. The insurance commissioner is authorized three full-time equivalent positions, including an attorney, a pharmacist, and an investigator, for this purpose.

SECTION 14. EFFECTIVE DATE. Section 3 of this Act becomes effective January 1, 2026.

SECTION 15. EXPIRATION DATE. Section 10 of this Act is effective through June 30, 2029, and after that date is ineffective.

SECTION 16. EMERGENCY. This Act is declared to be an emergency measure.