HEALTH CARE COMMITTEE

The Health Care Committee was assigned four studies:

- Section 1 of House Bill 1567 (2025) directed a study of the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities, and an assessment of dental provider workforce capacity and support strategies to improve access for these populations.
- Section 1 of Senate Bill 2249 (2025) directed a study of historical health care mandates.
- Section 3 of Senate Bill 2280 (2025) directed a study of the ability for health care systems and providers to submit prior authorization reviews for nonurgent and emergency health care services by secure electronic means.
- Section 1 of Senate Bill 2370 (2025) directed a study of reporting requirements for covered entities in North Dakota which participate in the federal drug discount program under 42 U.S.C. § 256(b) and how reported data could be used to develop public policy that benefits patients in North Dakota.

The Legislative Management assigned the committee the responsibility to receive four reports:

- A biennial report from the State Fire Marshal on the State Fire Marshal's findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes, pursuant to North Dakota Century Code Section 18-13-02(6).
- An annual report from the Department of Health and Human Services (DHHS) by November 1 of each year summarizing the number of deaths that occurred in the state caused by or related to fentanyl consumption during the preceding calendar year, including the county in which the deaths occurred and the age and gender of the deceased individuals, pursuant to Section 19-03.1-23.5.
- A biennial report from DHHS before June 1 of each even-numbered year regarding progress made toward the recommendations provided in Section 23-43-04, regarding stroke centers and stroke care, and any recommendations for future legislation.
- An annual report from the Maternal Mortality Review Committee regarding the identification of patterns, trends, and policy issues related to maternal mortality, pursuant to Section 23-51-08.

Committee members were Representatives Carrie McLeod (Chairman), Karen Grindberg, Karen Karls, Lisa Meier, Jon O. Nelson, Mitch Ostlie, Karen M. Rohr, and Mary Schneider and Senators Judy Lee, Tim Mathern, Kristin Roers, and Desiree van Oosting.

UNMET DENTAL AND ORAL HEALTH CARE NEEDS STUDY

Section 1 of House Bill 1567 (2025) directed a study of the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities, and an assessment of dental provider workforce capacity and support strategies to improve access for these populations.

Background

Dental and Oral Health Care Access

Access to dental and oral health care is affected by the availability of dentists and dental support staff, the geographic distribution of providers, the cost of services, insurance coverage, and other factors that may affect an individual's ability to obtain care. According to the DHHS Oral Health Program, in 2022, only 44 percent of the state's need for dental providers was being met. At that time, the state had 69 dental care practitioner shortage areas serving approximately 153,291 individuals, and 19 of the state's 53 counties did not have any dentists. According to the State Board of Dental Examiners, from 2020 to 2025, the number of in-state dentists fluctuated between 409 and 431, and the total number of dentists, including out-of-state dentists, increased from 473 to 520. The number of in-state dental hygienists increased from 694 to 737, and the number of in-state registered or qualified dental assistants increased from 687 in 2020 to 704 in 2025, following fluctuations between the period.

Certain populations experience additional barriers to dental and oral health care. Children from lower-income households generally experience higher rates of cavities and untreated tooth decay than children from higher-income households. Children with intellectual or developmental disabilities have increased risks of certain oral health conditions and may require additional time, specialized services, or providers with experience treating individuals with disabilities. Barriers identified for individuals with disabilities include cost, insurance coverage, financial resources, availability of appropriate providers, and transportation or geographic limitations. Native American children and adults also experience disparities in oral health outcomes and access to preventive dental services due to the limited availability of providers, challenging socioeconomic circumstances, and limited access to culturally representative care. More than one-third of North Dakota counties do not have a dentist, and many Native American communities are located in areas with limited access to health care and dental providers.

Access to dental services also varies based on insurance coverage and the type of dental benefits available. Medicaid provides dental coverage for eligible individuals enrolled in traditional Medicaid, subject to program requirements, coverage limitations, and service authorization requirements. Dental providers participating in Medicaid must comply with requirements relating to enrollment, credentialing, billing, coding, documentation, prior authorization, and payment. Medicaid Expansion provides medical coverage to eligible adults ages 19 through 64 but generally does not include dental or vision coverage.

Cost also is a factor affecting whether individuals obtain dental care. Unlike medical insurance, which generally limits an individual's annual out-of-pocket costs, dental benefit plans commonly include annual maximum benefit amounts that limit the amount an insurer will pay for covered dental services during a benefit year. After an annual maximum is reached, an individual may be responsible for the full cost of additional covered services.

Dental Education and Workforce

North Dakota does not have a dental school. Seventy-three dental schools in the United States accepted 1st-year students for the 2024-25 academic year, with 12,491 applicants competing for 7,013 1st-year openings. The majority of dentists practicing in this state graduated from dental schools in Minnesota or Nebraska. In 2024, there were 48.33 dentists per 100,000 people and 68 dental care health practitioner shortage area designations in this state.

The Center for Rural Health has identified the limited number of dental school enrollment openings nationwide as a factor affecting the dental workforce in North Dakota. Studies conducted in other states regarding the establishment of dental schools have considered factors including unmet dental care needs, population and demographic trends, projected costs of establishing and maintaining an accredited dental school, student demand, and the ability to recruit and retain faculty. Establishment and continued operation of an accredited dental school in this state would require funding for faculty, staff, facilities, equipment, and other costs and would be subject to the financial requirements associated with accreditation.

North Dakota has dental assisting and dental hygiene education programs at the North Dakota State College of Science, Dakota College at Bottineau, and Bismarck State College, and predentistry programs at several colleges and universities. The North Dakota State College of Science offers certificate and associate degree programs in dental assisting and an associate degree program in dental hygiene. Dakota College at Bottineau established dental assisting and dental hygiene programs in Minot, including a 10-month Dental Assisting Certificate Program and a 2-year Dental Hygiene Program. In 2024, the State Board of Higher Education approved Bismarck State College to offer programs in dental assisting and dental hygiene and a certificate in dental careers awareness. Bismarck State College also established Mystic Smiles Dental Clinic, a nonprofit teaching dental practice that combines clinical education with community service and provides pediatric dental care for children through age 13. Dental education programs include classroom, laboratory, and clinical training, with students participating in clinical experiences at dental practices and other community settings.

North Dakota also has programs designed to recruit and retain dental providers in areas with identified needs. The Dental Loan Repayment Program provides selected dentists with up to $100,000 in educational loan repayment in exchange for a 5-year full-time service commitment in an area with a defined need for dental services. Applicants must accept Medicare and Medicaid patients. A federal loan repayment program also is available to eligible dentists and dental hygienists practicing at qualifying public or nonprofit sites.

The state previously operated a Dental Practice Grant Program for new dental practices. Created in 2007, the program provided grants of up to $50,000 to dentists who had graduated from an accredited dental school within the preceding 5 years and established a new dental practice in a city with a population of 7,500 or less. Under the program, a recipient was required to practice in the community for at least 5 years, and the community was required to provide a matching contribution. The program was modified in 2011 to allow an in-kind community match and was discontinued and repealed in 2015.

Testimony

The committee received testimony from representatives of DHHS, higher education institutions, dental providers and clinics, the Indian Affairs Commission, the North Dakota Dental Association, the Community HealthCare Association of the Dakotas and North Dakota Oral Health Coalition, the North Dakota State Board of Dental Examiners, the Insurance Department, and rural federally qualified health centers.

The committee received testimony from representatives of DHHS regarding dental benefits for Medicaid recipients which indicated Medicaid provides preventive, diagnostic, restorative, and specialized dental services and includes additional payments for certain services provided to individuals with developmental disabilities and residents of long-term care facilities. In fiscal year 2025, 275 dentists were enrolled as Medicaid providers, 235 of whom provided services to Medicaid recipients. Medicaid dental utilization increased from 30,085 recipients in state fiscal year 2020 to 37,034 in

2024, before declining to 33,979 in 2025. Dental expenditures increased from approximately $17.45 million in 2020 to $27.95 million in 2025. The committee also received testimony from a representative of the department regarding the Oral Health Program and its efforts to improve oral health through prevention, education, surveillance, community partnerships, and workforce initiatives. The committee was informed about school-based preventive services, dental student rotations in federally qualified health centers, medical-dental integration, community water fluoridation, oral health surveillance, and programs providing preventive and restorative services to underserved children.

Representatives of Bismarck State College and other dental education programs described efforts to expand the state's dental workforce through dental assisting and dental hygiene programs. Bismarck State College's Qualified Dental Assistant Program includes up to 144 hours of online coursework and 300 hours of clinical externship experience at dental offices. The committee also received information regarding the Mystic Smiles Dental Clinic, which opened in July 2025 as a nonprofit dental clinic providing pediatric dental services. The clinic accepts Medicaid and offers an income-based sliding-fee scale for uninsured families.

The committee received testimony from dental providers and representatives from nonprofit dental organizations regarding barriers to providing dental services to low-income and underserved populations, including the limited availability of providers who accept Medicaid, the absence of dental coverage for adults enrolled through Medicaid Expansion, difficulties associated with staffing shortages, and the challenges of providing care to patients who are uninsured or underinsured. The testimony indicated dental providers and nonprofit organizations are making efforts to expand access to dental services, which include implementing sliding-fee programs, clinical rotations, mobile dental services, and charitable care. The committee also received testimony regarding the role of dental clinics in providing care to children, individuals with disabilities, and other populations with limited access to dental services.

A representative of the Indian Affairs Commission provided information regarding dental care services and access challenges affecting Native American populations. The testimony described dental services provided through Indian Health Service and tribal health facilities, tribal dental assistance programs, mobile and outreach services, partnerships with outside dental providers, geographic barriers, the availability of dental providers, and efforts by tribal health organizations to provide preventive and restorative dental services to tribal members.

The committee received testimony from a representative of the North Dakota Dental Association regarding the perspectives of members of the association. The testimony contended emergency visits for dental pain strain the health care system. Limited care can be provided at these visits because patients are seen by medical doctors, not dental providers, which leaves the underlying cause of the pain untreated. The testimony indicated utilization of Medicaid is impacted by both the numbers of beneficiaries seeking care and the providers delivering care.

The committee received testimony from a representative of the State Board of Dental Examiners regarding the dental workforce and licensing of dentists and dental staff, which indicated an ongoing effort to streamline the process and requirements for dental licensure. All licenses are required to be issued by the board within 10 days, but most are completed in 1 to 3 days. The duties and training of qualified dental assistants have expanded, allowing them to perform more invasive duties and procedures safely, and the role of hygienists has expanded to include administering local anesthetic to minors.

A representative of the Insurance Department provided information regarding dental insurance plans, including coverage and cost considerations affecting access to dental services. The testimony indicated the department reviews forms and rates for all dental plans in the state for the individual and group market. Dental insurance typically covers preventive care, basic procedures, and in some cases, major dental work. Preventive care procedures typically include routine checkups, cleanings, and x-rays. Basic care procedures may include fillings, extractions, and periodontal treatments. Coverage levels and plan designs vary. The committee was informed there is little federal regulation of dental insurance, which allows each insurer to create and design its own plan and coverage amounts.

The committee received testimony from federally qualified health centers regarding the challenges of providing dental services in rural communities, including workforce recruitment, staffing, Medicaid participation, and the financial challenges associated with serving patients who lack dental coverage. Testimony from a representative of a federally qualified health center indicated that of the patients at that center, approximately 28 percent are uninsured, 39 percent have Medicaid, and 33 percent are covered by other insurance plans.

The committee received testimony from a representative of Bridging the Dental Gap regarding dental services provided to Medicaid recipients, uninsured and underinsured individuals, and low-income individuals. Bridging the Dental Gap was established in 2004 and is a nonprofit stand-alone dental clinic that does not receive federal or state funding. The clinic has eight operatories, four full-time dentists, three full-time hygienists, seven full-time assistants, four full-time front desk personnel, billing and preoperative clerks, an executive director, and contract dentists. Fifty-five percent of the clinic's patients are Medicaid recipients, 15 percent had other insurance, and 30 percent qualified for a sliding-fee discount.

A representative of the Community HealthCare Association of the Dakotas and North Dakota Oral Health Coalition provided recommendations for addressing unmet dental and oral health care needs. The testimony identified five priority areas: increasing funding and access for safety-net and mobile dental programs; expanding the scope and utilization of dental hygienists and other dental professionals to provide preventive and restorative services; promoting dental professions and encouraging practice in North Dakota through education and loan repayment programs; improving access to dental education; and increasing Medicaid reimbursement. The recommendations were presented as potential strategies for addressing workforce shortages and improving access to care in rural and underserved communities.

The committee received testimony from DHHS regarding the Dentists' Loan Repayment Program. The testimony indicated a dentist may receive up to $100,000 in loan repayment paid over a 5-year service commitment, and applicants must have outstanding dental education loan debt and be licensed or eligible for licensure in North Dakota. The criteria used in selecting participants include the number of dentists providing services in an area, access to dental services in the surrounding community, and whether a dentist accepts Medicaid patients. The committee received information regarding the number of applicants and dentists awarded during the two preceding bienniums and was informed four dentists were awarded state program funds in 2025, with additional dentists receiving federal funding.

Committee Considerations

The committee considered a bill draft relating to the Dentists' Loan Repayment Program. The bill draft increases the loan repayment amount from $100,000 to $150,000 per dentist and decreases the required service commitment from 5 to 3 years.

The committee considered a bill draft relating to a grant program to support the coordination of oral health workforce and access initiatives. The bill draft provides a one-time $300,000 General Fund appropriation to DHHS for a statewide oral health initiative grant to support a full-time executive director at an eligible nonprofit organization to coordinate statewide oral health workforce, access, education, data, and partnership initiatives. The committee expressed reservations about funding an individual rather than care, while recognizing the need for coordination of access to services statewide.

The committee considered a bill draft relating to establishing the fluoride varnish program. The bill draft establishes a statewide program administered by DHHS in coordination with public health units to provide fluoride varnish at no cost to children enrolled in first grade at public and nonpublic schools and expands the type of health care provider who may apply topical fluoride varnish provided certain training and supervision requirements are met. The committee discussed parental choice regarding the application of fluoride varnish and approved a revision specifying that fluoride varnish may not be applied to a child without the consent of the child's parent or legal guardian. The committee also discussed collecting and reporting program outcome data to the Legislative Management and approved a revision requiring the department to report on program outcomes each interim.

Committee members noted the bill drafts represent a positive step toward addressing the state's unmet dental and oral health care needs.

Recommendations

The committee recommends a bill draft [27.0308.01000] relating to the Dentists' Loan Repayment Program.

The committee recommends a bill draft [27.0310.01000] relating to a grant program to support the coordination of oral health workforce and access initiatives.

The committee recommends a bill draft [27.0319.02000] relating to establishing the fluoride varnish program.

HISTORICAL HEALTH CARE MANDATES STUDY

Section 1 of Senate Bill 2249 (2025) directed a study of historical health care mandates, including an analysis of current health care mandates, when the mandates were enacted, their purpose, effectiveness, and present applicability, and a history of health care mandates and step therapy protocols.

Background

State Health Insurance Mandates

State health insurance mandates apply only to certain state-regulated health plans, including plans sold on the federal Affordable Care Act's individual and small-group marketplaces and fully insured employer-sponsored plans. The federal Employee Retirement Income Security Act of 1974 generally preempts state health insurance mandates that otherwise would apply to self-insured employer-sponsored health plans. Instead, mandates for self-insured employer-sponsored health plans are established under federal law and policy.

Section 54-03-28 establishes a process for measures that mandate health insurance coverage of services or payment for specified providers. As originally enacted in 2001, Section 54-03-28 required a cost-benefit analysis before a legislative measure mandating health insurance coverage could be considered by a legislative committee. The analysis is required to address the extent to which the proposed mandate would increase or decrease the cost of the service, the appropriate use of the mandated service, administrative expenses and insurance premiums, and the effect on total health care costs.

The mandate process was modified in 2003 to provide a new health insurance mandate initially applies to the Public Employees Retirement System (PERS) health insurance plans for a limited period before consideration of expansion to private health insurance plans. Subsequent legislation further modified the process, including changes in 2021 which established a procedure for identifying proposed mandates and changes in 2025 which modified responsibilities relating to the Insurance Commissioner and PERS and clarified when a cost-benefit analysis is required.

Under the current process, a new mandate initially applies to PERS health plans for the next biennium. Following the initial period, legislation may be considered to continue the mandate for PERS plans and expand the mandate to private health insurance plans. A proposed mandate must be considered by the Employee Benefits Programs Committee, and an actuarial report may be obtained when the mandate would have a fiscal impact on the health plans of the state or a political subdivision.

In 2001, the Legislative Assembly directed a study of existing mandated health insurance coverage and the feasibility and desirability of repealing state laws mandating coverage. The study included an evaluation of the cost or effect of existing mandates on insurance premiums compared with the benefits provided. The Insurance Commissioner categorized the mandates into four types: service mandates, which require coverage of specified treatments, illnesses, services, or procedures; beneficiary mandates, which identify categories of individuals who must receive benefits; provider mandates, which require insurers to pay for services provided by specified providers; and administrative mandates, which address insurance requirements that may increase administrative expenses. The study identified 23 statutory specified mandates, consisting of 13 service mandates, 6 beneficiary mandates, 3 provider mandates, and 1 administrative mandate.

Following the 2001 study, the Legislative Assembly adopted three health insurance mandates that subsequently were expanded to the private insurance market:

- Senate Bill 2252 (2007) required coverage for health services related to suicide, attempted suicide, or self-inflicted injury.
- Senate Bill 2140 (2023) and House Bill 1114 (2025) established coverage requirements for insulin and related medical supplies and limited out-of-pocket costs for those items.
- House Bill 1038 (2015) and Senate Bill 2052 (2017) established and expanded coverage requirements for telehealth services, including audio-only services for certain e-visits and virtual check-ins.

Essential Health Benefits

The Affordable Care Act requires nongrandfathered individual and small-group health insurance plans to cover essential health benefits. The essential health benefit categories include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Essential health benefits are based on state-specific benchmark plans. North Dakota selected Sanford Health Plan as its benchmark plan for 2014 through 2016. For 2017 through 2024, the state selected a Blue Cross Blue Shield of North Dakota small-group plan as the benchmark plan. In 2025, the federal Centers for Medicare and Medicaid Services approved changes to North Dakota's benchmark plan, including enhanced coverage for certain services and insulin cost-sharing limits.

Step Therapy

Step therapy is a utilization management practice under which a patient generally must try a preferred medication or therapy and find it ineffective before a nonpreferred medication or therapy will be covered. Step therapy commonly is used for therapeutic classes of drugs that include multiple medications with comparable effectiveness or generic alternatives.

North Dakota law places limited restrictions on step therapy protocols. Section 19-02.1-16.3 prohibits a pharmacy benefits manager or health plan from requiring step therapy for a recommended prescription drug used to treat metastatic cancer when the drug is prescribed consistently with federal Food and Drug Administration-approved indications or supported by medical literature.

North Dakota law does not provide a general step therapy exception process allowing a patient or provider to request coverage of a nonpreferred medication without completing the applicable step therapy requirements. Iowa, Minnesota, and South Dakota are among the states that have enacted laws requiring a step therapy exception process.

Testimony

The committee received testimony from insurers, health care providers, PERS, the Insurance Department, and other interested stakeholders.

The committee received testimony from insurers regarding the effect of state health insurance mandates on health plan administration, premiums, coverage, utilization, and access to care. The testimony described the distinction between mandates that require coverage of a particular service or benefit and other statutory or regulatory requirements affecting insurers. The testimony emphasized the importance of the use of utilization management and step therapy protocols to manage prescription drug costs and utilization of an exceptions process when a patient's circumstances warrant use of a treatment that does not satisfy the insurer's normal step therapy requirements. The committee was informed of the administrative effects of changes to mandated benefits and the interaction between state requirements and requirements applicable to federally regulated health plans.

The committee received testimony from a representative of PERS regarding the process applicable to health insurance proposals affecting the Uniform Group Insurance Program. The committee was informed about the role of the Employee Benefits Programs Committee in reviewing proposals that affect the health plan for state employees and employees of political subdivisions and the use of actuarial or other technical analysis to determine the potential effect of proposed changes. The testimony also described the timing of the PERS process in relation to the commercial insurance mandate process and the effect legislation may have on premiums and the Health Insurance Reserve Fund.

A representative of the Insurance Department provided historical and regulatory information regarding insurance mandates. The testimony indicated a 2002 study identified 23 insurance mandates in North Dakota, categorized as 13 service mandates, 6 beneficiary mandates, 3 provider mandates, and 1 administrative mandate. Examples included requirements relating to mammograms, substance abuse and mental health treatment, newborn and adopted children, continuation or conversion of coverage, freedom of choice for pharmacy services, and information disclosure. The representative of the department explained insurance requirements may address coverage of specific services, beneficiaries, providers, or administrative matters, as well as patient cost-sharing. From the department's regulatory perspective, the term "mandate" also encompasses requirements throughout the insurance statutes relating to disclosures, annual statements, claims processing, provider networks, free-look periods, and grace periods. State insurance requirements generally apply to fully insured policies, while private employer self-funded plans generally are not subject to state insurance benefit mandates.

A representative of the Insurance Department described the effect of the Affordable Care Act on the state's treatment of health insurance benefit mandates. North Dakota selected an essential health benefits benchmark plan, and under the federal framework, a proposed requirement generally is evaluated to determine whether it requires coverage of a benefit outside the benchmark plan. The department distinguishes benefit mandates from provider, beneficiary, and administrative requirements when determining whether a proposed law may trigger a state defrayal obligation. The department reported it monitors proposed legislation affecting health insurance and evaluates whether a proposal constitutes a new benefit mandate subject to federal defrayal requirements. The testimony also indicated, beginning in 2028, a separate state benefit mandate may trigger a defrayal obligation even if the benefit is included in the state's essential health benefits benchmark, and outlined the federal criteria for determining whether a requirement is subject to defrayal.

A representative of the Insurance Department provided examples of how proposed requirements have been treated under the federal framework. Telehealth requirements enacted in 2015 were not considered new benefit mandates because the underlying office, inpatient, or outpatient services were already covered benefits and the requirements concerned the method of service delivery. Similarly, insulin requirements enacted in 2021 and 2023 were characterized as cost-sharing limits applied to an existing prescription drug benefit rather than as new benefits outside the benchmark plan. In contrast, the department identified infertility coverage requirements as an example of a benefit mandate because infertility benefits were excluded from the state's benchmark plan.

The committee received testimony from a provider regarding the relationship between insurance coverage, access to care, step therapy, and health care costs. The testimony described the financial circumstances of health care systems and the effect of delayed or inadequate coverage on patients and providers. The provider reported it operates on an approximately one-cent per dollar margin and provides approximately $539.2 million annually in community contributions, including charity care, costs in excess of Medicaid payments, uncompensated care, and discounts provided to uninsured patients. Emergency departments are required under the federal Emergency Medical Treatment and Labor Act to screen and stabilize patients regardless of insurance status or ability to pay.

Testimony from a provider indicated step therapy is a utilization management tool that may require a patient to try one or more treatments before the insurer will cover another treatment. There is a connection between step therapy and other coverage requirements to the broader issue of ensuring patients receive care in an appropriate setting and avoiding circumstances in which patients delay care or seek treatment through emergency departments.

Committee Considerations

The committee considered differences in state approaches to health care mandates, the application of state requirements to different types of health plans, and the importance of evaluating whether existing mandates continue to serve their intended purposes. The committee recognized the complexity of federal requirements, the potential effects of mandates on insurers and providers, and the importance of transparency in the development and review of coverage requirements.

Conclusion

The committee makes no recommendation regarding its study of historical health care mandates.

ELECTRONIC PRIOR AUTHORIZATION STUDY

Section 3 of Senate Bill 2280 (2025) directed a study of the ability for health care systems and providers to submit prior authorization reviews for nonurgent and emergency health care services by secure electronic means.

Background

Prior authorization is a review conducted before or, in certain circumstances, after the delivery of a health care service to determine the medical necessity of a service, procedure, facility admission, or other health care. The review is conducted by a person other than the attending health care professional. North Dakota law contains several provisions governing prior authorization, although relatively few specifically address the method used to submit a request. Section 23-01-38 requires drug prior authorization requests to be accessible through a provider's electronic prescribing software and to be accepted electronically through a secure electronic transmission by the payer, insurer, or pharmacy benefit manager responsible for the authorization or denial.

In February 2024, the federal Centers for Medicare and Medicaid Services issued a final rule addressing interoperability and prior authorization. The rule establishes requirements intended to improve the electronic exchange of health care information and the prior authorization process for certain federally regulated health plans. The affected plans include Medicare Advantage organizations, state Medicaid fee-for-service programs, Medicaid managed-care plans, the state Children's Health Insurance Program, managed-care entities, and qualified health plan issuers on federally facilitated exchanges. The rule requires these payers to implement and maintain a prior authorization application programming interface through which providers can determine whether a service requires prior authorization, identify documentation requirements, and receive information regarding whether a request has been approved, denied, or requires additional information. Initial requirements took effect January 1, 2026, with remaining requirements scheduled to take effect January 1, 2027.

States have adopted different requirements governing electronic submission of prior authorization requests. South Dakota and Montana do not expressly require electronic submission and recognize written or electronic submission methods. Minnesota requires utilization review organizations, health plans, and claim administrators to allow providers to submit prior authorization requests by telephone, fax, voicemail, or electronic means and requires health plan companies to report certain information regarding electronic submissions.

Other states have established more specific electronic submission requirements. Indiana requires utilization review entities to accept prior authorization requests through secure electronic transmission or an application programming interface, subject to specified exceptions. New Mexico requires health insurers that use prior authorization to maintain an electronic portal and provide for electronic submission, receipt, tracking, and certain automated determinations. Oregon requires insurers to provide a secure electronic method for submitting requests and supporting documentation and to provide an electronic acknowledgment of receipt. West Virginia requires prior authorization forms to be submitted through an electronic portal and establishes requirements for the information and functionality available through the portal.

Testimony

The committee received testimony from health care providers, insurers, the Information Technology Department, the North Dakota Hospital Association, and representatives of the pharmaceutical and health care industries.

Testimony from a representative of a health care system indicated prior authorization requests are submitted through electronic direct connections, web-based portals, fax, telephone, and traditional mail. Electronic submission was identified as the most efficient method because it can reduce processing time and allow determinations to be returned directly to the health care organization. Testimony from a provider indicated in 2024, 66 full-time employees handled

more than 700,000 prior authorization requests. Testimony described the administrative resources required to process prior authorization requests and noted electronic processes may allow for greater automation, including the ability to initiate a prior authorization workflow following a provider's order.

Testimony from insurers indicated many providers continue to use telephone and fax processes. Barriers to increased electronic submission include technology limitations, differences among payer systems, and provider readiness. Testimony from insurers described the use of electronic prior authorization tools to identify requests that do not require prior authorization, automatically process certain requests, and obtain information from electronic health records. Electronic submission may reduce incomplete requests and administrative errors and allow providers to receive determinations more quickly.

Testimony from a representative of an insurer indicated that based on responses collected by the insurer from three health care providers, prior authorization requests generally are submitted through electronic platforms and other specialized portals, with fax or paper submissions used primarily as a backup when electronic systems are unavailable or inadequate. The committee also was informed of the challenges with connections between some electronic platforms and federal programs, including Medicaid Expansion authorization requests.

After launching a prior authorization checkpoint portal in April 2024, an insurer reported unnecessary prior authorization submissions declined from 40 percent to 16 percent, fax submissions decreased more than 97.9 percent between 2024 and 2025, and portal use increased 172.2 percent. The insurer reported receiving 460 faxed prior authorization submissions from 42 providers in 2025, including 376 nonurgent inpatient requests. Sixty-two percent of electronic prior authorization requests receive determinations within 2 hours, and 43 percent of electronic prior authorizations are processed automatically.

Representatives of the Information Technology Department provided information regarding cybersecurity, health information exchange, interoperability, and the technical considerations associated with electronic prior authorization. Secure electronic transmission depends on appropriate access controls, authentication, encryption, and information technology infrastructure. The department's health information exchange facilitates the exchange of health information but was not designed specifically for prior authorization. The testimony indicated implementing additional prior authorization workflows would require coordination among multiple stakeholders and consideration of data sharing and governance requirements. Manual processes may continue to be necessary during system outages or other cybersecurity-related disruptions.

A representative of the North Dakota Hospital Association indicated the results of a survey found hospitals submitted approximately 90 percent of prior authorization requests electronically in urban hospitals and 72 percent in rural critical access hospitals. Other submission methods include fax, telephone, and email. Barriers to electronic submission include payers that do not support electronic submission, the need to use different electronic systems for different payers, staff training and workflow challenges, and limitations of electronic health records. Hospitals sometimes submitted requests through nonelectronic methods when a payer's portal was unavailable, the payer did not offer electronic submission, or the payer instructed the hospital to submit requests by fax.

The committee received testimony from interested stakeholders regarding prior authorization requirements for medications and the potential effect of those requirements on access to nonopioid pain management therapies. The testimony addressed the role of prior authorization in utilization management and circumstances in which prior authorization requirements may affect the timing of access to medication following hospital discharge.

Committee Considerations

Although the committee considered information regarding the use of electronic methods for submitting prior authorization requests, the committee recognized the costs associated with electronic prior authorization systems and barriers faced by providers and payers, including technology and workforce costs for rural hospitals.

Conclusion

The committee makes no recommendation regarding its study of electronic prior authorization.

PRESCRIPTION DRUG TRANSPARENCY REPORTING STUDY

Section 1 of Senate Bill 2370 (2025) directed a study of reporting requirements for covered entities in North Dakota which participate in the federal drug discount program under 42 U.S.C. § 256(b) and how reported data could be used to develop public policy that benefits patients in North Dakota.

Background

In 1992, Congress established the 340B Drug Pricing Program. The program requires participating drug manufacturers to provide covered outpatient drugs at discounted prices to eligible health care providers. The Health

Resources and Services Administration, within the United States Department of Health and Human Services, administers the program. Eligible entities include federally qualified health centers, tribal and urban Indian health centers, children's hospitals, critical access hospitals, rural referral centers, and other specified providers. For federal fiscal year 2023, 340B drug sales represented an estimated 7.2 percent of the United States prescription drug market. Covered entities may purchase eligible drugs at prices estimated to be 25 to 50 percent below other prices.

Covered entities may dispense 340B drugs through their own pharmacies or enter agreements with outside pharmacies, referred to as contract pharmacies. In 2010, the Health Resources and Services Administration issued guidance permitting covered entities to contract with an unlimited number of pharmacies, subject to federal program requirements. The number of contract pharmacies increased from approximately 1,300 in 2010, to 20,000 in 2017. In 2020, the Department of Health and Human Services issued an advisory opinion stating manufacturers were required to deliver 340B drugs to an unlimited number of contract pharmacies. A federal district court subsequently determined the advisory opinion was arbitrary, and the department withdrew the opinion in June 2021. Manufacturers also have imposed restrictions on the distribution of 340B drugs through contract pharmacies, leading to litigation over the extent of manufacturers' obligations under federal law.

Several states have enacted laws restricting manufacturers from limiting covered entities' use of contract pharmacies. In *Pharmaceutical Research and Manufacturers of America v. McClain*, 95 F.4th 1136, 1141 (8th Cir.), the Eighth Circuit Court of Appeals upheld an Arkansas law prohibiting manufacturers from restricting covered entities' ability to contract with outside pharmacies. The court concluded the federal 340B statute did not preempt the state law because the law regulated drug delivery rather than drug pricing. The court also determined the contract pharmacies acted as agents of the covered entities when dispensing the drugs. Other states' laws addressing contract pharmacy arrangements have been subject to separate federal court challenges.

In 2025, the North Dakota Legislative Assembly enacted House Bill 1473, codified in Section 43-15.3-08(3). The law makes it a Class B misdemeanor for a drug manufacturer or specified related entity to take certain actions that deny, restrict, prohibit, or otherwise interfere with a contract pharmacy's acquisition of a 340B drug on behalf of a covered entity, subject to an exception for conduct prohibited by federal law. Pharmaceutical manufacturers filed federal lawsuits challenging the law. The pharmaceutical manufacturers argue the law conflicts with federal regulation of the 340B program and violates constitutional limits on state authority. The lawsuits were consolidated for proceedings in the United States District Court for the District of North Dakota. *See Astrazeneca Pharmaceuticals LP v. Wrigley*, 1:25-cv-00182 (D.N.D. Aug 01, 2025).

Testimony

The committee received testimony from hospitals, federally qualified health centers, insurers, pharmaceutical manufacturers, DHHS, the Insurance Department, the State Board of Pharmacy, and the North Dakota Pharmacists Association.

Representatives of the Insurance Department testified regarding the use of 340B savings, the extent to which savings benefit patients and underserved communities, and oversight of participating entities. The testimony contended the original purpose of the 340B program was to support safety net providers like federally qualified health centers, critical access hospitals, and rural clinics. Concerns raised regarding the program include providers potentially using the program as a revenue stream, savings not reaching patients and underserved communities, and a lack of accountability for manufacturers or providers. The department noted federal guidance issued in 2010 allowed covered entities to contract with an unlimited number of outside pharmacies and other states had adopted reporting requirements for covered entities. The committee was informed the department had not received direct consumer complaints regarding the program and could collect and report information if the Legislative Assembly established clearly defined reporting requirements.

Testimony from a representative of DHHS indicated manufacturers participating in Medicaid must enter rebate agreements and the average drug rebate was 49 percent. Medicaid generally may not claim a manufacturer rebate for drugs purchased through the 340B program because the discounted purchase price and a Medicaid rebate may not both apply to the same drug. Department representatives also discussed restrictions on the use of 340B drugs in Medicaid Expansion and the department's responsibility to comply with federal requirements.

Testimony from representatives of hospitals and federally qualified health centers described the 340B program's use to support patient care and services. Testimony from a provider indicated participating hospitals must maintain eligibility and compliance records, prevent duplicate Medicaid rebates and diversion of discounted drugs to ineligible patients, and retain contract pharmacy records for audit purposes. Testimony from a provider indicated program savings are used to support mental health and substance use services, a sliding-fee drug discount program, patient transportation, and uncompensated care. Testimony from a representative of a federally qualified health center indicated providers are required to provide care regardless of a patient's ability to pay and reported patients at those centers generally pay

approximately $1 more than the drug acquisition cost. Testimony also described the administrative costs associated with compliance and indicated concerns that additional reporting requirements could require additional staff or outside consultants. A rural provider's testimony indicated the provider receives between $800,000 and $1 million in annual revenue derived from the 340B program and uses those funds to offset hospital operating costs.

A representative of the American Hospital Association reported representing more than 5,000 hospitals nationwide, including approximately 2,000 participating in the 340B program, and described the use of contract pharmacies to dispense medications to patients, including patients in rural areas. The testimony contended the 340B program was established as a solution to high and rising drug prices and was designed to support the different health care needs of communities by allowing each hospital to decide how to best expand access to health care services. The 340B program is funded entirely through discounts provided by drug companies, rather than through taxpayer funds, and eligibility is limited to six types of public or private nonprofit hospitals, including critical access hospitals and disproportionate share hospitals. The discounted 340B program price is calculated by subtracting the unit rebate amount from the average manufacturer price. The unit rebate amount is a minimum percentage discount off the drug's average manufacturer price and varies based on the type of drug. The testimony indicated hospitals use the 340B program savings based on the unique needs of patients and many hospitals have programs that reduce the costs of drugs and provide charity care to patients.

A representative of a pharmaceutical manufacturer reported having 33 member companies and, since 2000, its member companies invested more than $1 trillion in research for treatments and cures. The testimony attributed nearly 3,500 North Dakota jobs, nearly $1 billion in economic output, and $60 million in annual tax revenue to those activities. The testimony indicated North Dakota has the second highest utilization rate of 340B drugs in the country. The testimony also indicated 88 percent of North Dakota hospitals participating in the 340B program provided charity care below the national average and from 2014 through 2022, 340B hospital assets increased by 55 percent while uncompensated care decreased by 36 percent. Nationally, 68 percent of 340B audits resulted in adverse findings. In North Dakota, 14 audits have been conducted since 2015, and 50 percent resulted in adverse findings. The testimony contended North Carolina, Minnesota, and Indiana have increased reporting requirements and information collected through those requirements could be used in policy decisions concerning state employee health plan costs and pharmacy benefit manager reforms.

Testimony from a representative of the State Board of Pharmacy reported the board had received no formal complaints and did not conduct any investigations involving fraudulent or concerning 340B activity. The testimony indicated North Dakota previously had a prescription drug transparency reporting program administered by the Insurance Department which was repealed. A representative of the North Dakota Pharmacists Association described contract pharmacies' role in dispensing medications to patients served by covered entities. The testimony indicated contract pharmacies must maintain separate inventory for the program and incur additional staffing costs to administer the arrangements. The testimony also indicated the three largest pharmacy benefit managers accounted for 26 percent of contract pharmacy arrangements in the program.

A representative of an insurer indicated the insurer serves approximately 400,000 North Dakotans and pharmacy costs account for nearly 30 percent of the insurer's health care expenditures. The testimony indicated North Dakota ranked first nationally in 340B revenue per capita and described how manufacturers may provide discounted 340B pricing to participating facilities or rebates to insurers, but not both for the same drug. Testimony from an insurer indicated insurers and pharmacy benefit managers report prescription drug information to the Insurance Department, health plans are not covered entities under the 340B program, and insurers seek the lowest net drug cost regardless of 340B status.

The committee received an update from a representative of the Attorney General's office regarding litigation challenging House Bill 1473 (2025), which established state requirements relating to the 340B program. Pharmaceutical manufacturers filed lawsuits against the state in 2025, and the cases are pending in federal court. In April 2026, the federal district court granted summary judgment to the pharmaceutical manufacturers, concluding federal law preempted state regulation of the 340B program. *See Astrazeneca Pharmaceuticals LP v. Wrigley*, No. 1:25-cv-00182 (D.N.D. Apr. 27, 2026). In August 2026, the Eighth Circuit Court of Appeals granted the state's request to stay the injunctions in the cases pending appeal. As a result, the law remains in effect. The federal government filed an amicus brief supporting the manufacturers' position that federal law preempts state regulation, while hospital associations filed an amicus brief supporting the state's position that the law is constitutional. The testimony noted manufacturers generally had been unsuccessful in challenging similar state laws in other jurisdictions, although differing outcomes among federal courts ultimately could lead to review by the United States Supreme Court.

Committee Considerations

The committee considered the benefits and challenges associated with the 340B program, including how program savings may be used to support patient services, reduce health care costs, and offset uncompensated care. The committee recognized differing perspectives regarding the program's growth, transparency, accountability, and the extent to which savings benefit patients.

The committee considered potential state-level prescription drug transparency reporting requirements, including the types of information that could be reported, the entities that could be subject to reporting requirements, and the public availability of reported information. The committee also considered the administrative burden of additional reporting requirements, existing federal oversight and reporting requirements, and the potential effects of additional requirements on participating health care providers and patients.

The committee considered ongoing federal policy developments and litigation involving state regulation of the 340B program and recognized these developments may affect the scope and enforceability of potential state legislation.

Conclusion

The committee makes no recommendation regarding its study of prescription drug transparency reporting.

REQUIRED REPORTS

State Fire Marshal Report

Section 18-13-02 directs the State Fire Marshal to review the effectiveness of the section and report any findings and recommendations to the Legislative Management. Section 18-13-02 requires all cigarettes sold or offered for sale in the state to be tested in accordance with the American Society of Testing and Materials (ASTM) E2187-04. The report submitted by the State Fire Marshal recommended amending Section 18-13-02(1)(a) to update the specific reference to ASTM E2187-04 with ASTM E2187-24, which is the current standard test method for measuring the ignition strength of cigarettes. The report also recommended legislation requiring thermal fuses, commonly referred to as firebreaks, at both the oxygen source and the patient interface for all home oxygen installations in the state to reduce fire severity and prevent oxygen-fed fire propagation.

Fentanyl Consumption Report

The committee received reports from DHHS regarding a summary of deaths that occurred in the state caused by or related to fentanyl consumption, including overdose trends, prevention and treatment efforts, and naloxone distribution. The report indicated a decline in unintentional drug overdose deaths from 2022 through 2024. There were 606 unintentional drug overdose deaths from 2021 through 2025, including a preliminary count of 110 deaths in 2025. Fentanyl was identified in approximately 67 percent of the deaths, with fentanyl-related overdose deaths declining 16 percent between 2023 and 2025.

Stroke Report

The committee received a report from DHHS regarding progress made toward the recommendations provided in Section 23-43-04, relating to stroke centers and stroke care. The report indicated DHHS maintains a comprehensive stroke system that ensures nationally recognized guidelines and protocols are followed with the intention to improve outcomes and reduce stroke-related mortality and morbidity.

Maternal Mortality Report

The committee received a report from the Maternal Mortality Review Committee, as required by Section 23-51-08, which indicated from 2021 through 2023, there were 17 maternal deaths in North Dakota. The report indicated the leading underlying causes of pregnancy-related death include mental health conditions, cardiovascular conditions, infection, hemorrhage, and embolism. Challenges indicated in the report included the immense impact mental health disorders have on maternal mortality and morbidity.