2021 HOUSE GOVERNMENT AND VETERANS AFFAIRS

HB 1233

2021 HOUSE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Pioneer Room, State Capitol

HB 1233
2/4/2021

Provide for the PERS to contract for an audit of pharmacy benefit managers providing contract services for the state uniform group health insurance program; and to provide for a legislative management report

Chairman Kasper opened the hearing on HB 1233 at 10:25 a.m. **Vice Chairman B. Koppelman** took over while Rep. Kasper testified.

Representatives	Roll Call
Representative Jim Kasper	P
Representative Ben Koppelman	P
Representative Pamela Anderson	P
Representative Jeff A. Hoverson	P
Representative Karen Karls	P
Representative Scott Louser	P
Representative Jeffery J. Magrum	A
Representative Mitch Ostlie	P
Representative Karen M. Rohr	P
Representative Austen Schauer	P
Representative Mary Schneider	P
Representative Vicky Steiner	P
Representative Greg Stemen	P
Representative Steve Vetter	P

Discussion Topics:

- Audit of the pharmacy benefit manager for PERS

Rep. Kasper introduced the bill and testified in favor.
Mike Schwab, Executive Vice President, ND Pharmacists Association, testified in favor, #5455.

Scott Miller, Executive Director, NDPERS, testified neutral, #5238.

Additional written testimony: #5240, #5241, #5254

Chairman Kasper closed the hearing at 11:21 a.m.

Carmen Hart, Committee Clerk

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House Government and Veterans Affairs Committee
HB 1233 - Chairman Jim Kasper
Pioneer Room 2/4/2021

Chairman Kasper and members of the committee, for the record, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1233 relating to an audit of the pharmacy benefit manager (PBM) used in managing the prescription drug benefit for the North Dakota Public Employees Retirement System.

Before I get too far into my testimony, I must clarify our support for this bill. Again, we are supportive of the concept of the bill but feel there are issues with the current bill language that need to be addressed. Chairman, if you do not object, I will review some of our concerns with the current bill language.

If you look at page 1 – lines 8-9 where it references chapter 19-03.6:

I might be wrong, but that chapter of century code became law back in 2011 and is intended for how audits are to be conducted of pharmacies by pharmacy benefit managers. I know the title says "pharmacy benefit manager – audits" but again, if you read that chapter it seems clear the intent of the language deals with audits of pharmacies by pharmacy benefit managers, not an audit of the pharmacy benefit manager contract and certain aspects or guarantees in the PBM contract.

If you look at page 1 – lines 9-11:

It states the public employee retirement system may not select a competitor of the pharmacy benefit manager, pharmaceutical manufacturer, etc. We suggest using language similar in other areas of ND Century Code such as "the public employee retirement system shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefit manager or board."

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If you look at page 1 – lines 13-15:

This provision speaks to confidentiality. I respectfully comment that this section needs to be carefully thought through. In some cases, the pharmacy benefit manager has confidentiality agreements they have created and drafted for audits such as this which prevent any findings or certain findings from being disclosed. Maybe narrowing the confidentiality aspect to those things that can be proven to be "trade secrets" would fall under a locked confidentiality order.

As one moves through the rest of the bill, it is very comprehensive in terms of all the areas to be audited. While this is good, it is often cost prohibitive and time intensive. Again, I mean no disrespect, but I would suggest limiting the audit to areas that have the most impact and potentially the greatest financial impact. The areas I am referencing deal with performance audits that deal with drug price guarantees (brand, generic, specialty drugs, etc.), payments made for drugs, administrative fees and other financial benefit guarantees.

Again, there are a number of good things listed in the bill such as (1) auditors may not be compensated based on financial findings or recoveries and compensation must be on a flat fee or hourly basis; (2) access to certain claims and transaction data; (3) reimbursement costs; (4) data and documents provided by the pharmacy benefit manager may not be redacted or altered; and compensation back to the public employee retirement system for improper implementation, etc.

If you look at page 5 – lines 1-8:

This section speaks to overpayments made by NDPERS and I feel it is important to look at overpayments. However, in the same spirit, if we are looking at overpayments, we should also be looking at underpayments to providers as well. In addition, if overpayments or fraud is identified, we need to allow the respective parties identified an opportunity to respond to the allegations and/or

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findings. We give the pharmacy benefit manager the same opportunity in the last section of the bill, so I feel it is naturally fair to give all parties the same opportunity.

Lastly, I would like to touch on the fiscal note attached to this bill. I am a little confused by the fiscal note. First, maybe it is best to limit the audit language to only the commercial side of the public employee retirement system or at least to start to minimize cost. Regardless, I am not sure why 3 different PBMs were listed in the fiscal note. I can understand two PBMs due to NDPERS using one PBM for their commercial plan and one for their retiree plan. Even if you issue an RFP for the Part D plan, I assume you would still only have one PBM for that plan not two? I am sure others will explain why three PBMs were listed in the fiscal note.

Also, the fiscal note is based off the assumption that all areas of the bill will be used in conducting the audit. **If you look at page 1 – lines 18-20.** You will see the language states NDPERS and the auditors will pick ONE or more areas to be audited which may include…and then it lists the different areas to pick from. The fiscal note appears to be based off if ALL areas mentioned in the bill would be audited. Maybe I am reading that wrong.

That concludes my testimony, and I would be happy to try and answer any questions you might have for me.

Respectfully Submitted,

Mike

Mike Schwab
EVP - NDPhA

TESTIMONY OF SCOTT MILLER

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

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

Section 1

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

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

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

Section 2

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

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

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

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

Section 3

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

Section 4

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

Fiscal Note

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

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

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

Summary

In recognition of the above, NDPERS would suggest:

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

February 4, 2021

My name is Daniel Weiss, and I serve as the Senior Executive Director for Pharmacy at Sanford Health Plan. I will be available for questions and support to the testimony of Scott Miller for SB 1233.

Thank you.

My contact information is Daniel.Weiss@Sanfordhealth.org

Office 605 3122748

Cell: 605 940 2686

TESTIMONY OF DERRICK HOHBEIN

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good afternoon, my name is Derrick Hohbein. I am the Chief Operating/Financial Officer of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in a neutral position on House Bill 1233. I am available should there be any questions related to the impact of the bill on any of the NDPERS benefits.

TESTIMONY OF REBECCA FRICKE

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good afternoon, my name is Rebecca Fricke. I am the Chief Benefits Officer of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in a neutral position on House Bill 1233. I am available should there be any questions related to the impact of the bill on any of the NDPERS benefits.

2021 HOUSE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Pioneer Room, State Capitol

HB 1233
2/19/2021

Provide for the PERS to contract for an audit of pharmacy benefit managers providing contract services for the state uniform group health insurance program; and to provide for a legislative management report

Chairman Kasper opened the committee work meeting at 10:01 a.m.

Representatives	Roll Call
Representative Jim Kasper	P
Representative Ben Koppelman	P
Representative Pamela Anderson	P
Representative Jeff A. Hoverson	P
Representative Karen Karls	P
Representative Scott Louser	P
Representative Jeffery J. Magrum	P
Representative Mitch Ostlie	P
Representative Karen M. Rohr	P
Representative Austen Schauer	P
Representative Mary Schneider	P
Representative Vicky Steiner	P
Representative Greg Stemen	P
Representative Steve Vetter	P

Discussion Topics:

- Performance PBM audit

Chairman Kasper explained his proposed amendment 21.0147.01005, #7027.

Rep. Steiner moved to **adopt the amendment. Rep. Rohr** seconded the motion. **Voice vote. Motion carried.**

Rep. Rohr moved **Do Pass as amended and rerefer to appropriations. Rep. Schneider** seconded the motion.

Representatives	Vote
Representative Jim Kasper	Y
Representative Ben Koppelman	Y
Representative Pamela Anderson	N
Representative Jeff A. Hoverson	Y
Representative Karen Karls	Y
Representative Scott Louser	Y
Representative Jeffery J. Magrum	Y
Representative Mitch Ostlie	Y
Representative Karen M. Rohr	Y
Representative Austen Schauer	Y

Representative Mary Schneider	Y
Representative Vicky Steiner	Y
Representative Greg Stemen	Y
Representative Steve Vetter	Y

Motion passed. 13-1-0. **Chairman Kasper** is the carrier.

Chairman Kasper ended at 10:14 a.m.

Carmen Hart, Committee Clerk

21.0147.01005
Title.02000

Prepared by the Legislative Council staff for
Representative Kasper
February 18, 2021

2/19/21

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1233

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to amend and reenact section 54-52.1-04.16 of the North Dakota Century Code, relating to public employees retirement system prescription drug coverage performance audits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52.1-04.16 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.16. Prescription drug coverage - Performance audits - Report to employee benefits programs committee.

1. Except for Medicare part D, prescription drug coverage, the board may not enter or renew a contract for prescription drug coverage, whether contracting directly with a pharmacy benefits manager, providing prescription drug coverage through a self-insurance plan, or contracting with a carrier, unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services.

2. During the term of the contract for the prescription drug coverage, the board shall conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management service. The performance audit must be conducted directly through the pharmacy benefits manager providing the prescription drug coverage and may not be conducted through an intermediary, such as the carrier. The contract for prescription drug coverage must provide:

   a. The board and auditor must have full access to claim-level data regarding:

      (1) The total amount of dollars paid to the pharmacy benefits manager by the carrier and the board, including detail by prescription to arrive at the aggregate total amounts;

      (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier and the board which were not subsequently paid to a licensed pharmacy in the state; ~~and~~

      (3) Payments made to all pharmacy providers which shows line item detail to include product reimbursement and dispensing fees as two separate fields to arrive at the aggregate total amounts; and

      (4) Any recoupment by the pharmacy benefits manager either at the point of sale or retrospectively, including the reason and the reason code.

b. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

c. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

e. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. ~~The contract must provide that~~That all drug rebates, financial incentives, fees, and discounts must be disclosed to the board at the national drug code level.

g. The terms of the contract between the carrier and the pharmacy benefits manager.

~~2.~~3. The following apply to conducting a performance audit as required under this section:

a. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board such as an existing contract with that entity. The board may not compensate the auditor based on financial findings or recoveries resulting from an audit. All audit compensation must be on a flat fee or hourly basis.

b. Data and documents provided by the pharmacy benefits manager to the board or the auditor may not be redacted or altered by the pharmacy benefits manager. The ~~board's auditor, the~~ insurance department~~,~~ and the employee benefits programs committee may access any information the board and the auditor may access under this section. All information accessed by the board, ~~board's~~ auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This ~~subsection~~subdivision does not limit the information required to be disclosed to the board and the auditor under subsection 1. This subdivision does not limit the access to information that is not a trade secret.

2/19/21

c. The performance audit must include a review of financial terms and guarantees and performance guarantees, including administrative fees, annual brand prescription guarantees, annual generic prescription guarantees, annual specialty drug guaranteed discounts, and financial benefit guarantees listed in the pharmacy benefits manager contract to validate the terms of the contract are being met.

d. The performance audit must include a review of medical prescription drug claim rebates at the national drug code level and the amounts and verify who retained the rebates for such drugs.

e. The pharmacy benefits manager shall disclose to the board and the auditor the terms of any contract or arrangement the pharmacy benefits manager has with a rebate aggregator, regardless of whether self-owned or with an outside entity that functions as a rebate aggregator for the pharmacy benefits manager, regardless of whether self-described as a rebate aggregator.

f. The pharmacy benefits manager shall provide all data and documents necessary to enable the board and the auditor to calculate any compensation the pharmacy benefits manager shall pay to the public employees retirement system if a program or contract guarantee was not properly implemented.

~~3. If the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.~~

4. ~~Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to~~The board shall report to the employee benefits programs committee the report of each performance audit conducted under this section."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1233: Government and Veterans Affairs Committee (Rep. Kasper, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). HB 1233 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to amend and reenact section 54-52.1-04.16 of the North Dakota Century Code, relating to public employees retirement system prescription drug coverage performance audits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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2. During the term of the contract for the prescription drug coverage, the board shall conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management service. The performance audit must be conducted directly through the pharmacy benefits manager providing the prescription drug coverage and may not be conducted through an intermediary, such as the carrier. The contract for prescription drug coverage must provide:

   a. The board and auditor must have full access to claim-level data regarding:

      (1) The total amount of dollars paid to the pharmacy benefits manager by the carrier and the board, including detail by prescription to arrive at the aggregate total amounts;

      (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier and the board which were not subsequently paid to a licensed pharmacy in the state; ~~and~~

      (3) Payments made to all pharmacy providers which shows line item detail to include product reimbursement and dispensing fees as two separate fields to arrive at the aggregate total amounts; and

      (4) Any recoupment by the pharmacy benefits manager either at the point of sale or retrospectively, including the reason and the reason code.

   b. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

c. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

e. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. ~~The contract must provide that~~That all drug rebates, financial incentives, fees, and discounts must be disclosed to the board at the national drug code level.

g. The terms of the contract between the carrier and the pharmacy benefits manager.

~~2.~~3. The following apply to conducting a performance audit as required under this section:

a. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board such as an existing contract with that entity. The board may not compensate the auditor based on financial findings or recoveries resulting from an audit. All audit compensation must be on a flat fee or hourly basis.

b. Data and documents provided by the pharmacy benefits manager to the board or the auditor may not be redacted or altered by the pharmacy benefits manager. The ~~board's auditor, the~~ insurance department~~,~~ and the employee benefits programs committee may access any information the board and the auditor may access under this section. All information accessed by the board, ~~board's~~ auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This ~~subsection~~subdivision does not limit the information required to be disclosed to the board and the auditor under subsection 1. This subdivision does not limit the access to information that is not a trade secret.

c. The performance audit must include a review of financial terms and guarantees and performance guarantees, including administrative fees, annual brand prescription guarantees, annual generic prescription guarantees, annual specialty drug guaranteed discounts, and financial benefit guarantees listed in the pharmacy benefits manager contract to validate the terms of the contract are being met.

d. The performance audit must include a review of medical prescription drug claim rebates at the national drug code level and the amounts and verify who retained the rebates for such drugs.

e. The pharmacy benefits manager shall disclose to the board and the auditor the terms of any contract or arrangement the pharmacy benefits manager has with a rebate aggregator, regardless of whether self-owned or with an outside entity that functions as a rebate aggregator for the pharmacy benefits manager, regardless of whether self-described as a rebate aggregator.

f. The pharmacy benefits manager shall provide all data and documents necessary to enable the board and the auditor to calculate any compensation the pharmacy benefits manager shall pay to the public employees retirement system if a program or contract guarantee was not properly implemented.

~~3. If the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.~~

4. ~~Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to~~The board shall report to the employee benefits programs committee the report of each performance audit conducted under this section."

Renumber accordingly

21.0147.01005
Title.

Prepared by the Legislative Council staff for
Representative Kasper
February 18, 2021

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      (3) Payments made to all pharmacy providers which shows line item detail to include product reimbursement and dispensing fees as two separate fields to arrive at the aggregate total amounts; and

      (4) Any recoupment by the pharmacy benefits manager either at the point of sale or retrospectively, including the reason and the reason code.

b. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

c. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

e. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. ~~The contract must provide that~~That all drug rebates, financial incentives, fees, and discounts must be disclosed to the board at the national drug code level.

g. The terms of the contract between the carrier and the pharmacy benefits manager.

~~2.~~3. The following apply to conducting a performance audit as required under this section:

a. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board such as an existing contract with that entity. The board may not compensate the auditor based on financial findings or recoveries resulting from an audit. All audit compensation must be on a flat fee or hourly basis.

b. Data and documents provided by the pharmacy benefits manager to the board or the auditor may not be redacted or altered by the pharmacy benefits manager. The ~~board's auditor, the~~ insurance department~~,~~ and the employee benefits programs committee may access any information the board and the auditor may access under this section. All information accessed by the board, ~~board's~~ auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This ~~subsection~~subdivision does not limit the information required to be disclosed to the board and the auditor under subsection 1. This subdivision does not limit the access to information that is not a trade secret.

c. The performance audit must include a review of financial terms and guarantees and performance guarantees, including administrative fees, annual brand prescription guarantees, annual generic prescription guarantees, annual specialty drug guaranteed discounts, and financial benefit guarantees listed in the pharmacy benefits manager contract to validate the terms of the contract are being met.

d. The performance audit must include a review of medical prescription drug claim rebates at the national drug code level and the amounts and verify who retained the rebates for such drugs.

e. The pharmacy benefits manager shall disclose to the board and the auditor the terms of any contract or arrangement the pharmacy benefits manager has with a rebate aggregator, regardless of whether self-owned or with an outside entity that functions as a rebate aggregator for the pharmacy benefits manager, regardless of whether self-described as a rebate aggregator.

f. The pharmacy benefits manager shall provide all data and documents necessary to enable the board and the auditor to calculate any compensation the pharmacy benefits manager shall pay to the public employees retirement system if a program or contract guarantee was not properly implemented.

~~3. If the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.~~

4. ~~Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to~~The board shall report to the employee benefits programs committee the report of each performance audit conducted under this section."

Renumber accordingly

21.0147.01005

Sixty-seventh
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1233

Introduced by

Representatives Kasper, Jones, Keiser, Lefor, Louser, Meier, Rohr, Schauer, Steiner

A BILL ~~for an Act to provide for the public employees retirement system to contract for an audit of pharmacy benefit managers providing contract services for the state uniform group health insurance program; and to provide for a legislative management report.~~for an Act to amend and reenact section 54-52.1-04.16 of the North Dakota Century Code, relating to public employees retirement system prescription drug coverage performance audits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

~~**SECTION 1. AUDIT OF PHARMACY BENEFIT MANAGER - AUDIT REQUIREMENTS.** During the 2021-22 interim, the public employees retirement system shall contract for an audit of every pharmacy benefit manager providing contract services for the uniform group health insurance program under chapter 54-52.1. The audit must be conducted in accordance with chapter 19-03.6. The public employees retirement system may not select a vendor that is a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor. The contract for the audit must include the following provisions:~~

~~1. The public employees retirement system and the auditors each shall execute a confidentiality agreement with the pharmacy benefit manager before commencement of the audit.~~

~~2. The audit must be conducted during normal business hours and must not cause undue interference to the pharmacy benefit manager's business activity.~~

~~3. The audit must include a review of financial terms and guarantees and performance guarantees in which the public employees retirement system and the auditors shall select one or more substantive areas to audit which may include:~~

~~a. Fees and financial guarantees, including administrative fee and additional fee requirements, average annual guarantees, specialty drug minimum guaranteed discounts, and financial benefit guarantees;~~

~~b. Performance guarantees if the public employees retirement system or plan beneficiaries believe performance guarantees are not being satisfied;~~

~~c. Passthrough pricing requirements for covered item ingredient costs and for dispensing fees;~~

~~d. Passthrough pricing requirements for financial benefits;~~

~~e. Pharmacy benefit manager requirements of any program implemented by the public employees retirement system; and~~

~~f. Eligibility.~~

~~4. The audit must ensure all benefit plan designs and each program and program protocol have been loaded accurately into the pharmacy benefit manager's computer systems for the public employees retirement system. If there are material subsequent changes by the pharmacy benefit manager to the public employees retirement system benefit setup, the public employees retirement system or the auditors may conduct an additional setup review on reasonable notice after the pharmacy benefit manager makes changes to verify the subsequent changes were properly set up by the pharmacy benefit manager.~~

~~5. The audit must include a review of the pharmacy benefit manager's enrollment, eligibility, and invoicing for eligible plan beneficiaries. The public employees retirement system shall execute the necessary attestation indicating its compliance with the federal Health Insurance Portability and Accountability Act of 1996, enabling the public employees retirement system or the auditors to conduct an audit of the pharmacy benefit manager's enrollment, eligibility, and invoicing, subject to the federal Health Insurance Portability and Accountability Act of 1996 privacy requirements for providing minimum necessary data.~~

~~6. The audit must include a review of the pharmacy benefit manager's fraud, waste, and abuse program to allow the public employees retirement system and the auditors to verify the pharmacy benefit manager has an adequate program for the prevention, detection, and correction of pharmaceutical fraud, waste, and abuse.~~

~~7. The public employees retirement system may not compensate the auditors based on financial findings or recoveries resulting from an audit. All audit compensation must be on a flat fee, or hourly, basis.~~

~~**SECTION 2. AUDIT OF PHARMACY BENEFIT MANAGER - AVAILABILITY OF INFORMATION.** As provided for in section 1 of this Act, within thirty days of requesting the information, the pharmacy benefit manager shall produce and grant access to the public employees retirement system and the auditors to all documents and data needed to audit the pharmacy benefit manager's performance with the state, including:~~

~~1. Claims data and transactions for the audit period, including the pharmacy benefit manager's invoiced costs for each item dispensed from a retail pharmacy, mail order pharmacy, or a specialty drug pharmacy, and the pharmacy benefit manager's reimbursement costs to each pharmacy for each item.~~

~~2. Retail pharmacy, mail order pharmacy, and specialty pharmacy dispensed claim transactions. For all specialty pharmacy dispensed claim transactions selected, the public employees retirement system and the auditors must be able to verify the pharmacy benefit manager's payment to the vendor through examination of the relevant and unredacted American national standards institute 835 health care claims payment and advice records and the pharmacy benefit manager's bank statements.~~

~~3. Other data needed by the public employees retirement and system and the auditors to verify all programs identified as part of the audit have been properly implemented by the pharmacy benefit manager. The pharmacy benefit manager also shall provide all data and documents necessary to enable the public employees retirement system and the auditors to calculate any compensation the pharmacy benefit manager shall pay to the public employees retirement system if a program was not properly implemented.~~

~~4. All information necessary for the public employees retirement system and the auditors to audit passthrough pricing requirements related to financial benefits. The information provided must be sufficient for the auditors to assess whether the pharmacy benefit manager has:~~

~~a. Passed through the appropriate pro rata share of financial benefits;~~

~~b. Accurately performed an annual reconciliation of financial benefits; and~~

~~c. Kept a detailed accounting of each component of financial benefits, including a breakdown by manufacturer and the type of financial benefit, such as pharmaceutical manufacture rebates, health management fees, data sales fees, and other information requested by the auditors.~~

~~5. Documents transmitted to third parties. The pharmacy benefit manager shall transmit all electronic and other data requested by the public employees retirement system or the auditors. To enable the public employees retirement system and the auditors to verify public employees retirement system claims data is not being sold to third parties, the pharmacy benefit manager shall provide relevant documents transmitted to specific third parties and copies of pharmacy benefit manager and pharmaceutical manufacturer contracts, pharmacy benefit manager invoices to pharmaceutical manufacturers, and pharmaceutical manufacturers' payments, credits, discounts, or other financial benefits made to the pharmacy benefit manager, including remittance statements. All documents must be produced by the pharmacy benefit manager at the pharmacy benefit manager's offices. The public employees retirement system and the auditors may make notes of the contents of all referenced documents but may not make copies of these documents.~~

~~6. The pharmacy benefit manager's roster of all plan beneficiaries and pertinent information, including plan beneficiary number, date of enrollment, and date of disenrollment. If any discrepancies between the pharmacy benefit manager and public employees retirement system enrollment data are discovered, the pharmacy benefit manager shall produce relevant claims data for those plan beneficiaries for whom there is a discrepancy, as permitted under the federal Health Insurance Portability and Accountability Act of 1996.~~

~~7. Data and documents provided by the pharmacy benefit manager to the public employees retirement system or the auditors may not be redacted or altered by the pharmacy benefit manager.~~

~~**SECTION 3. PHARMACY BENEFIT MANAGER AUDIT - DISPUTES AND LIABILITY.** As provided for in section 1 of this Act, the pharmacy benefit manager shall comply with the following dispute and liability provisions related to the audit:~~

~~1. If the public employees retirement system or the auditors discover the pharmacy benefit manager improperly inputted public employees retirement system benefit plan designs, the pharmacy benefit manager is liable for any costs resulting from the pharmacy benefit manager's error.~~

~~2. The pharmacy benefit manager shall take appropriate action if the audit reveals fraud or overpayment involving a participating pharmacy, including recoupment of overpayments from pharmacies for services and products provided to plan beneficiaries. If overpayments are detected as part of the audit, the overpayments must be adjusted retroactively in the relevant electronic claims data. If the pharmacy benefit manager recovers any amounts from a pharmacy related to the public employees retirement system claims as a result of the audit, the pharmacy benefit manager shall submit all recoveries to the public employees retirement system.~~

~~3. If the auditors conclude the pharmacy benefit manager violated its obligations to the public employees retirement system and the pharmacy benefit manager disputes the audit findings, the pharmacy benefit manager shall provide the basis of the dispute to the public employees retirement system and the auditors, with all supporting documentation, within thirty days of the pharmacy benefit manager's receipt of the disputed audit findings. The pharmacy benefit manager shall provide sufficient documentation to permit adequate review of the disputed issues, and has the burden of demonstrating the auditor's findings are incorrect. To the extent the pharmacy benefit manager fails to provide documentation substantiating any part of its position, or fails to meet its burden of proof, the pharmacy benefit manager waives its right to further dispute that matter. After receiving the pharmacy benefit manager's documentation, the public employees retirement system and the auditors shall review the documentation and advise the pharmacy benefit manager whether the auditors have changed the audit findings.~~

~~**SECTION 4. PHARMACY BENEFIT MANAGER AUDIT - LEGISLATIVE MANAGEMENT REPORT.** The public employees retirement system shall report the findings of the audit provided for in section 1 of this Act to the legislative management by July 1, 2022.~~

SECTION 1. AMENDMENT. Section 54-52.1-04.16 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.16. Prescription drug coverage - Performance audits - Report to employee benefits programs committee.

1. Except for Medicare part D, prescription drug coverage, the board may not enter or renew a contract for prescription drug coverage, whether contracting directly with a pharmacy benefits manager, providing prescription drug coverage through a self-insurance plan, or contracting with a carrier, unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services.

2. During the term of the contract for the prescription drug coverage, the board shall conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management service. The performance audit must be conducted directly through the pharmacy benefits manager providing the prescription drug coverage and may not be conducted through an intermediary, such as the carrier. The contract for prescription drug coverage must provide:

   a. The board and auditor must have full access to claim-level data regarding:

      (1) The total amount of dollars paid to the pharmacy benefits manager by the carrier and the board, including detail by prescription to arrive at the aggregate total amounts;

      (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier and the board which were not subsequently paid to a licensed pharmacy in the state; ~~and~~

      (3) Payments made to all pharmacy providers which shows line item detail to include product reimbursement and dispensing fees as two separate fields to arrive at the aggregate total amounts; and

      (4) Any recoupment by the pharmacy benefits manager either at the point of sale or retrospectively, including the reason and the reason code.

   b. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

c. The board and auditor must have full access to data regarding the ~~average~~per claim detail of reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated through any contractual agreement.

e. The board and auditor must have full access to data on an individual claim basis regarding any prospective and retrospective direct and indirect fees, charges, or recoupment, or any kind of assessments or effective rates imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. ~~The contract must provide that~~That all drug rebates, financial incentives, fees, and discounts must be disclosed to the board at the national drug code level.

g. The terms of the contract between the carrier and the pharmacy benefits manager.

~~2.~~3. The following apply to conducting a performance audit as required under this section:

a. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board such as an existing contract with that entity. The board may not compensate the auditor based on financial findings or recoveries resulting from an audit. All audit compensation must be on a flat fee or hourly basis.

b. Data and documents provided by the pharmacy benefits manager to the board or the auditor may not be redacted or altered by the pharmacy benefits manager.

The ~~board's auditor, the~~ insurance department~~,~~ and the employee benefits programs committee may access any information the board and the auditor may access under this section. All information accessed by the board, ~~board's~~ auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This ~~subsection~~subdivision does not limit the

information required to be disclosed to the board and the auditor under subsection 1. This subdivision does not limit the access to information that is not a trade secret.

c. The performance audit must include a review of financial terms and guarantees and performance guarantees, including administrative fees, annual brand prescription guarantees, annual generic prescription guarantees, annual specialty drug guaranteed discounts, and financial benefit guarantees listed in the pharmacy benefits manager contract to validate the terms of the contract are being met.

d. The performance audit must include a review of medical prescription drug claim rebates at the national drug code level and the amounts and verify who retained the rebates for such drugs.

e. The pharmacy benefits manager shall disclose to the board and the auditor the terms of any contract or arrangement the pharmacy benefits manager has with a rebate aggregator, regardless of whether self-owned or with an outside entity that functions as a rebate aggregator for the pharmacy benefits manager, regardless of whether self-described as a rebate aggregator.

f. The pharmacy benefits manager shall provide all data and documents necessary to enable the board and the auditor to calculate any compensation the pharmacy benefits manager shall pay to the public employees retirement system if a program or contract guarantee was not properly implemented.

~~3. If the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.~~

4. ~~Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to~~The board shall report to the employee benefits programs committee the report of each performance audit conducted under this section.

2021 SENATE HUMAN SERVICES

HB 1233

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1233
3/17/2021 AM

A BILL for an Act to amend and reenact section 54-52.1-04.16 of the North Dakota Century Code, relating to public employees retirement system prescription drug coverage performance audits.

Madam Chair Lee opened the hearing on HB 1233 at 8:59 a.m. Members present: Lee, K. Roers, Anderson, Hogan, Clemens, O. Larsen.

Discussion Topics:

- Contract bidding
- Emergency clause
- Audit types/scope
- Provider reimbursement

[9:00] Representative Jim Kasper, District 46. Introduced HB 1233 and provided the committee with proposed amendment 21.0147.02001 (testimony #9809).

[9:26] Mike Schwab, Executive Vice President, ND Pharmacists Association. Provided testimony #9810 in favor.

[9:42] Scott Miller, Executive Director, NDPERS. Provided testimony #9713 in opposition and provided the committee with Deloitte Consulting actuarial review of HB 1233 (testimony #9815).

Additional written testimony:

Gary Boehler, Consultant Pharmacists, Dakota Drug, Inc. Written testimony #9637 in favor and examples of generic drug pricing hikes (testimony #9636).

Madam Chair Lee closed the hearing on HB 1233 at 10:19 a.m.

Justin Velez, Committee Clerk

21.0147.02001
Title.

Prepared by the Legislative Council staff for
Representative Kasper
March 16, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1233

Page 4, line 4, after "implemented" insert ".

g. A document or information provided to the board or the auditor under this section is confidential commercial information and a trade secret, is exempt from public inspection, and is not a public record under section 44-04-18. A document or information provided to the board or the auditor under this section and the performance audit report prepared under this section may not be released to another person in a manner that allows for the identification of an individual drug or manufacturer or in a manner that has the potential to compromise the financial, competitive, or proprietary nature of the information"

Renumber accordingly

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

Senate Human Services Committee
HB 1233 – Madam Chair Judy Lee
3/17/21 – 9:00 A.M.

Madam Chair and members of the committee, for the record, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1233.

HB 1233 requires a performance audit of the prescription drug benefit for NDPERS, more specifically an audit of the PBM used to administer the prescription drug benefit. This bill was hog housed to better align with current laws related to performance audits under chapter 54-52.1-04.16., which deals with NDPERS. If it is okay with the committee, I would like to review the various sections of the bill to provide a little more context to the discussion.

Section 1 – This section clarifies the audit must be performed whether the contract is directly between NDPERS and the PBM, through a self-insurance plan or contracted through a carrier.

Section 2 – This section no longer makes it optional for NDPERS to conduct an audit. It requires an audit take place and requires the audit to be directly through the PBM and not the carrier. Subsections A-G clarify claim level data must be available to not only the NDPERS board but also the auditor who will be hired to conduct the audit. This subsection also spells out the type of claim level data that must be provided to the auditors. In addition, subsection G states the contract between the carrier and PBM must be disclosed to the auditor. This is a necessity so the auditor can see the specific performance guarantees in the contract. This also allows the auditor to evaluate if the PBM is adhering to the contract terms to the benefit of NDPERS or not.

Subdivision 3 – Letter A – This clarifies NDPERS must use an independent auditor and the NDPERS may not compensate the auditor based on "findings" and must be compensated on a flat fee or hourly basis.

Subdivision 3 – Letter B – This section clarifies the PBM may not redact or alter information that is to be provided to the auditor. This subdivision also outlines if information is considered "trade secret"; it would remain as a confidential record.

Subdivision 3 – Letter C – This section lists various audit elements that are important for the auditor to review. It will help the auditor validate if the terms and financial guarantees of the PBM contract are being met to the benefit of NDPERS and taxpayers.

Subdivision 3 – Letter D – This section references potential medical prescription drug rebates that are available under the NDPERS plan. It could help verify who retained the rebates and what dollar amounts are involved.

Subdivision 3 – Letter E – This section speaks to the fact that the large PBMs now own, and control and utilize rebate aggregators. These are companies that provide formulary rebate administrative services and distributes rebates back to the PBMs. This is important because PBMs often own the rebate aggregators where the money comes in one door and out the other all while being controlled and owned by the same entity. When the PBM says they pass along the rebate dollars, this is one way to verify if in fact the rebates make their way back to the employer as well as it will help show the degree to which the PBMs keep rebates or what types of fees, categories and broad exclusions are used when calculating rebates owed back to NDPERS.

Subdivision 3 – Letter F – This section outlines if the PBM did not adhere to the contract or did not meet certain guarantees listed in the contract and the PBM must pay back any potential monies to NDPERS.

The Last Section – Number 4 – clearly states the NDPERS board shall report any findings to the ND Employee Benefits Committee.

Given the fact that our member pharmacies are telling our office that NDPERS prescription benefit plan administered through Optum Rx pays North Dakota pharmacies below Medicaid rates in a large percent of claims, we support an audit of Optum Rx because as prescription drug costs to the NDPERS plan increase, we know it is not because pharmacies are paid too much. This bill will verify if the PBM is operating fairly and is adhering to the contract term guarantees. This audit could also identify if the PBM is making more than their fair share while underpaying pharmacies in this state. It is also our opinion based on evidence that ND pharmacies are subsidizing the NDPERS prescription drug benefit to a large degree. Yes, that is a bold statement. However, when pharmacies are consistently paid below Medicaid rates for the largest employer-based plan in the state, I am not sure how else it should be stated.

The most frustrating part for our members is this legislative assembly continues to authorize the 2.5 times Medicaid rates for the medical side of Medicaid Expansion which goes to benefit our healthcare facilities in the state. However, when it comes to the prescription drug benefit side of the largest employer-based taxpayer funded plan in the state, pharmacies are consistently paid below Medicaid rates. It is double standard that frankly put, in the 20 years that I have been a registered lobbyist, does more that frustrate me. If physicians, hospitals, dentists, or other healthcare providers were paid below Medicaid rates, how well would that be received and how long would it last?

This bill will help identify if the PBM is being fair, if the PBM is disclosing certain revenue streams, if the PBM is adhering to its contract obligations, and it will also identify if NDPERS is should possibly renegotiate its PBM contract terms and conditions to the benefit of the taxpayers of this state.

I would respectfully request an amendment to HB 1233. On page 6 – Lines 9-10 – Insert "current" and "2019, 2020 and current year" so the sentence reads "**During the current term of the contract for the prescription drug coverage, the board shall conduct a performance audit of 2019, 2020 and the current year of the prescription drug coverage and any related…etc.**

That concludes my testimony, and I would be happy to answer any questions you might have at this time. Thank you for your time and attention today.

Respectfully Submitted,

Mike Schwab

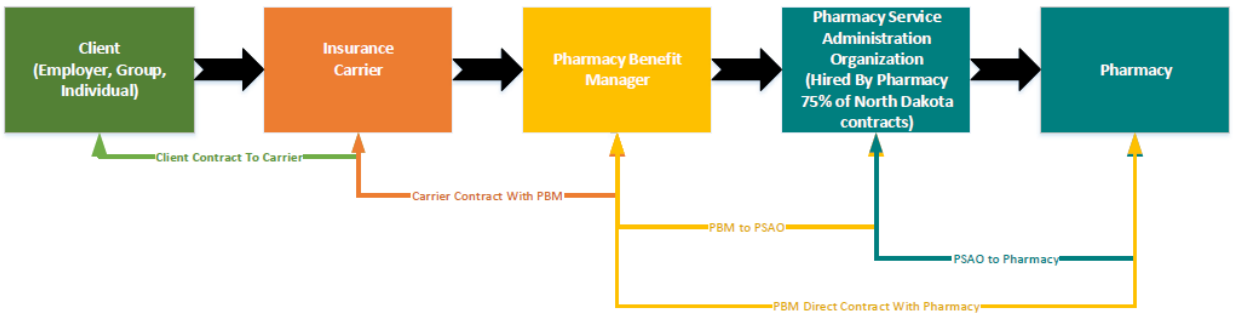
EVP - NDPhA

TESTIMONY OF SCOTT MILLER

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in opposition to House Bill 1233.

In a nutshell, House Bill 1233 requires the NDPERS Board to conduct audits that will be difficult if not impossible to perform, and require contractual provisions with future Pharmacy Benefits Managers, or PBMs, that may result in increased premiums for pharmacy benefits. The bill requires NDPERS to perform audits of the performance of contractual responsibilities for contracts to which we are not parties and will most likely not be able to gain access. The below graph will help me explain the problems, and the impossibilities, this bill presents.



In this graph, NDPERS is in the green box to the left – we are the client. We contract with Sanford Health Plan (SHP) for both our medical benefits and our pharmacy benefits – SHP is in the orange box above, second from the left. SHP does not directly provide the pharmacy benefits. Instead, SHP contracts with a PBM, OptumRx, to provide those services. The PBM is in the middle yellow box above. From a practical perspective, since we have a fully-insured plan, these are the only contracts we are concerned with. We have a vested interest that SHP is providing prescription benefits in the manner to which they have committed in our contract with them, and so the performance of the PBM in regard to its contract with SHP is something into which we can arguably inquire.

However, we are not as interested in how the PBM contracts with either pharmacies or pharmacy service administration organizations (PSAOs), and we have no interest in any contracts between PSAOs and pharmacies. PSAOs are in the second box from the

right, and pharmacies are in the far right box. For your information, a PSAO is an entity that contracts with a pharmacy to assist with third-party payer interactions and administrative services related to third-party payer interactions. Basically they help pharmacies contract with PBMs, or serve as an intermediary between a pharmacy and a PBM. Approximately 75% of pharmacies in North Dakota use PSAOs.

The biggest problem with HB 1233 is that even though we have little interest in auditing any performance under the contracts between our PBM and any PSAOs or pharmacies, and no interest in the contract between the pharmacies and the PSAOs, this bill requires us to audit certain performance under those contracts. Remember, we are not parties to those contracts. And we have no right to even see those contracts. With about 75% of North Dakota pharmacies using PSAOs, that is about 75% of the transactions that we will not be able to look at. The below list of new audit requirements shows which requirement applies to which contract:

Page 1, lines 22-24: NDPERS and SHP; SHP and OptumRx

Page 2, lines 1-3: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 4-6: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 7-8: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 9-13: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 14-17: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 18-23: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 24-27: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 28-29: SHP and OptumRx

Page 2, lines 30-31: SHP and OptumRx

Page 3, lines 2-6: NDPERS and SHP

Page 3, lines 7-16: NDPERS and SHP; SHP and OptumRx

Page 3, lines 17-22: SHP and OptumRx

Page 3, lines 23-25: NDPERS and SHP

Page 4, lines 1-4: SHP and OptumRx

The underlined sections above are the contracts to which we have no legal right to require access, much less audit. The activities HB 1233 seeks to have NDPERS audit are far down the transaction chain, in an area we do not have any right to impose any requirements. As an example, I just bought a bed over Amazon. The seller of that bed was not Amazon, but a company out of Wyoming called Murphy Wall Beds Warehouse (Murphy). They are the ones that shipped me the bed. But they are not the maker of the bed – the maker is a company called Night & Day Furniture.

As with the contract between NDPERS and SHP, I had a direct contract with Amazon. As with the contract between SHP and OptumRx, Amazon had a contract with Murphy. I had a relationship with Murphy because we had to coordinate shipping and delivery. Same with NDPERS and OptumRx – even though NDPERS does not have a direct contract with OptumRx, we still have significant requirements that they have to follow.

However, I had zero interest in the relationship between Murphy and Night & Day Furniture. If something went wrong with the order, I had every right to beat on Amazon and potentially even Murphy to make it right. I did not have any right to go past Murphy and take on Night & Day Furniture. I also had no right to ask Murphy about the contract between them and Night & Day Furniture; I presume Murphy made some money on our transaction, but I did not have any right to demand to know what that amount was or under what contractual requirements it was made.

Similarly, NDPERS has little interest in the relationship between OptumRx and the PSAOs or the pharmacies, and no interest whatsoever in the relationship between the PSAOs and the pharmacies. NDPERS does, of course, have a significant interest in how OptumRx provides benefits to our participants. If NDPERS has a problem with our pharmacy benefits, we go directly to SHP, and may even involve OptumRx – in fact, we required OptumRx to appear before the Board some time ago to explain some issues we were having.

But NDPERS has no right to get involved in the relationship between OptumRX and the PSAOs or pharmacies. And certainly no right to get involved in the relationship between the PSAOs and the pharmacies. Whether OptumRx or the PSAOs or the pharmacies have questions or concerns about the performance of the contracts between them is not something about which NDPERS has a right to intervene. We will not be able to force the PSAOs and pharmacies to disclose those contracts, and have no right to audit the performance of those contracts. However, House Bill 1233 would require us to audit many aspects of the performance of those contracts. NDPERS believes that is requiring us to do something that is neither our concern nor something that is possible for us to do. Because of that, we have to oppose House Bill 1233.

If our health plan was self-funded, we may be more interested – and we may have more rights – in looking farther into the stream of pharmaceutical commerce. Many of the new provisions would more directly apply if we were self-funded. But we are not self-funded – we have a modified fully insured health and pharmacy benefits plan. We are concerned about claims made to and claims paid by SHP and OptumRx. HB 1233 would require us to reach much further into the stream of commerce, into places we arguably have no right to go.

One of the arguments made on the House Floor in favor of HB 1233 is that there is a threat that our contract with SHP and their contract with OptumRx may involve what is called "spread pricing". The Centers for Medicare and Medicaid Services (CMS) describe "spread pricing" as follows:

> Spread pricing occurs when health plans contract with [PBMs] to manage their prescription drug benefits, and PBMs keep a portion of the amount paid to them by the health plans for prescription drugs instead of passing the full payments on to pharmacies. Thus, there is a spread between the amount that the health plan pays the PBM and the amount that the PBM reimburses the pharmacy for a beneficiary's prescription.

Spread pricing is common, if not universal, in "traditional" PBM contracts that are part of fully-insured plans. The alternative is a "transparent" PBM contract, which is typically found in self-insured plans. The agreement with OptumRx is, in fact, a transparent PBM contract, and is part of our modified fully-insured plan. NDCC section 54-52.1-04.16 already provides us the audit authority we need in order to be assured that spread pricing is not taking place.

The potential cost is another significant concern about House Bill 1233. I do not mean just the minimum $375,000 we will spend on the audits (or attempt to spend, since we most likely will not be successful in auditing all of what HB 1233 requires). If House Bill 1233 were to pass, we have concerns that we will not receive bids for our pharmacy benefit plan in the future, and, if we do, what the cost of that plan would be.

NDCC section 54-52.1-04.16 was originally created just last session – it is the codification of House Bill 1374 from the 2019 Legislative Assembly. When enacted, section 54-52.1-04.16 greatly expanded the audit requirements that NDPERS had to put in any contract for PBM services, including if we obtained those PBM services through a health insurance carrier like SHP.

The audit requirements imposed by section 54-52.1-04.16 are much more broad than are typically found in a fully-insured arrangement. As I stated above, usually fully-insured health plans use a "traditional" or "spread" PBM, which does not allow an in-

depth analysis of the claims paid. Instead, you pay a given amount for coverage, and they cover it, regardless of the cost.

Section 54-52.1-04.16 imposes audit requirements that go far beyond that. In fact, in our RFP process just last year for our health and pharmacy benefits, the "transparent" PBMs that responded to our RFP indicated that the audit requirements are more broad than even they tend to see. Those expanded audit requirements have already had an impact on competition for our plan; in their initial proposal, one of the vendors responded that it could not commit to complying with section 54-52.1-04.16. That entity only changed its response when we reminded them that it was a minimum qualification, and that their proposal would be deemed non-responsive if they could not commit to complying with that statute.

House Bill 1233 expands the breadth of auditing requirements well beyond that currently found in statute. If we had problems with that statute as it currently reads, we are seriously concerned about the problems we will have obtaining pharmacy benefits for our employees under the greatly expanded requirements from House Bill 1233.

Even if we do receive bids for the plan, those bids would most likely only be from "transparent" PBMs. During our bid process last year, we received bids from three "transparent" PBMs (other than OptumRx through the SHP contract). If we were required to use the least expensive of those PBMs, the state's premiums would have gone up another 5%, or nearly $32 million. Given that our total prescription drug spend for a biennium is just over $100 million, that is a 32% increase in our pharmacy cost. One has to question whether any information we might receive from an audit under HB 1233 is worth that increase in cost.

Further, the bill provides no alternatives for NDPERS if no party is willing to add these provisions. If NDPERS is not able to add this to its fully insured contract with SHP, which was just bid this last fall, does NDPERS need to rebid? If so, since there is not time to do a full rebid before the beginning of the next biennium, should NDPERS extend the existing contract until a new bid can be completed with the new minimum requirements? If NDPERS is not able to contract for these services with these minimum requirements with a PBM, then is it the intent of the bill that NDPERS would not provide prescription drug services to our members? Or would NDPERS have the authority to sign a contract with a PBM that met "most" of the requirements? We previously asked for this guidance, and have not yet received it. Accordingly, NDPERS must oppose House Bill 1233.

I would also again point out that the audit provisions in the current version of NDCC section 54-52.1-04.16 were just added last session – it became effective on August 1, 2019. The PBM we use, OptumRx, just began providing us services on January 1,

2019. There would have been almost nothing to audit once the statute became effective.

In January of 2020, we began the RFP process for our health and pharmacy benefits plan. With the potential of changing carriers as a result of the RFP, there was little reason to spend the money to audit a PBM that had only been providing us services for one calendar year and that we may replace for the next biennium. However, now that OptumRx has been providing PBM services to us for over two years, and we have awarded the new contract to SHP, which includes the required statutory language passed last session in HB 1374, this is a reasonable time to engage in an audit under the current parameters of NDCC 54-52.1-04.16. Those audit requirements are in the contract with SHP right now; the expanded audit requirements in HB 1233 are not, and may be difficult, if not impossible, to add. We would propose doing an audit under the current statute over the upcoming interim and presenting that information to the Employee Benefits Programs Committee. If the Legislative Assembly believes that audit is incomplete for any reason, it could easily add what it wants during the next session.

At the end of the day, the Legislative Assembly needs to make the policy decision regarding whether it intends to change the NDPERS RFP award process requirement of selecting the lowest cost, most beneficial bid, with the least financial risk to the state, that best meets the overall requirements. If the Legislative Assembly would like the NDPERS Board to continue with that methodology, then this bill needs to fail. Alternatively, additional wording is needed in the bill. The following wording is one way to provide this clarification in the bill:

> At the end of the bill add:
>
> "Section 2: A new section is added to chapter 54-52.1
>
> The requirements in 54-52.1-04.16 do not apply if:
> 1. No bidder offers a proposal that complies with 54-52.1-04.16; or
> 2. The bid or bids that comply with 54-52.1-04.16 are more costly than those that do not comply."

Alternatively, if the intent is to pursue the audit based on the assumption that it will net a return that will offset the cost of a higher bid, then the following language expresses this assumption:

> At the end of the bill add:
>
> "Section 2: A new Section is added to chapter 54-52.1
>
> The requirements in 54-52.1-04.16 do not apply if:

1. No bidder offers a proposal that complies with 54-52.1-04.16; or
2. The bid or bids that comply with 54-52.1-04.16 are more than 1% higher than the lower cost proposal meeting the requirements."

Also, additional wording should be added to the above if it is intended that these provisions would apply to 2021-23 contract.

Summary

In recognition of the above, NDPERS would suggest the following:

1. Clearly specify if it is the intent for NDPERS to audit an entity with which we do not have a contract.
2. Since the bill establishes minimum requirements that were not a part of the bid specification for 2021-23, consideration should be given to making it applicable beginning with the 2023-25 contract period so it can become a part of the minimum requirement for that contract or, if necessary, a new bid process. If this is to be effective for 21-23, and since it was not a part of the scope of work in that bid, we will need to renegotiate the arrangement with the new specifications.
3. Provide direction in the bill on what NDPERS should do if it is unable to get a contract with these provisions for the active and retiree plans.
4. If NDPERS is unable to get these provisions added to our existing fully insured contracts, should NDPERS have to rebid the plan before the beginning of the next biennium? If so, then consideration should be given to allowing NDPERS to offer a no bid contract since there would be insufficient time do a full bid or extending the existing arrangement until a new bid can be completed. It should also be noted that if a new bid is done, rates could change, and if they go up, NDPERS would need to cut benefits so they match the premium, or subsidize the premium from reserves. Notably, if the premiums go up the $32 million I mentioned above, we will nearly wipe out our reserves. If the Legislature would like to provide guidance to the Board on this it could be added to this bill.

We would also point out, again, that we already have very broad audit requirements in NDCC section 54-52.1-04.16 that the Legislative Assembly just passed last session. Last session, these broad audit requirements were apparently exactly what the Legislative Assembly wanted. We would suggest not passing this bill, giving NDPERS the opportunity to conduct an audit under the current requirements, and reviewing the results. If the Legislative Assembly does not see what it would like to see, it could address those deficiencies in the next session. There is no hurry. And haste may result in tens of millions of dollars of additional expenses, wiping out our reserves. The NDPERS Board urges this Committee to adopt a "do not pass" recommendation.

Deloitte.

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Memo

Date: March 1, 2021

To: Rep. Mike Lefor, Chairman
Employee Benefits Programs Committee

From: Josh Johnson and Drew Rasmussen, Deloitte Consulting LLP

Subject: **ACTUARIAL REVIEW OF PROPOSED BILL 21.0147.01005 (HB1233)**

The following summarizes our review of the proposed legislation as it relates to actuarial impact to the uniform group insurance program administered by NDPERS.

OVERVIEW OF PROPOSED BILL

The proposed bill specifies that NDPERS may not enter or renew a contract for prescription drug coverage, whether contracting directly with a pharmacy benefits manager, providing prescription drug coverage through a self-insurance plan, or contracting with a carrier, unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services. Also, the performance audit must be conducted directly through the pharmacy benefits manager providing the prescription drug coverage.

The proposed bill would not apply to Medicare Part D, which would exempt the NDPERS retirees that have prescription drug coverage through the NDPERS Employer Group Waiver Plan (EGWP).

ESTIMATED ACTUARIAL IMPACTS

PBM audits can uncover processing errors, missed financial guarantees, claim coding errors, etc. that can result in recoupment of funds from the PBM to the plan. Whether there are audit findings and the corresponding magnitude of the financial recoupments or penalties is specific to each separate audit. Due to this, the potential actuarial impact to the uniform group insurance program cannot be quantified in advance of the audit.

Regarding the cost to conduct the audits required by this bill, additional information will be necessary to accurately estimate the costs. The audits described in the bill are more extensive, and may include more parties, than a typical PBM performance audit performed by a plan sponsor. Fulfilling the scope may also require different types of audits. The estimated fee ranges below for different PBM audit components are based on input from Deloitte experts and market knowledge of what other firms might charge.

That said, these are estimates, the scope would need to be clarified, and bids from consultants and/or PBM audit firms would need to be received to confirm cost estimates.

- Claims/eligibility audit: $100,000 - $200,000
- Performance guarantee audit: $50,000 - $200,000
- Clinical audit/ fraud waste and abuse audit: $100,000 - $250,000
- Rebate audit: $75,000 - $150,000
- Validation of Benefits (VOB): $50,000 - $75,000

TECHNICAL COMMENTS

NDPERS currently provides prescription drug benefits coverage through two fully-insured insurance arrangements, one for employees and other eligible non-Medicare enrollees and a separate plan for Medicare eligible retirees.

For employees and other eligible non-Medicare enrollees the coverage is provided through the combined medical and prescription drug insurance program insured by Sanford Health Plan (SHP). NDPERS does not have a contract with the PBM that provides pharmacy claims adjudication for this program but rather contracts with SHP who subcontracts with OptumRx for PBM services. Due to this contract arrangement, the following considerations may be consequential to the proposed bill:

1) Under the fully-insured contract, NDPERS and SHP agreed to a fixed monthly premium. The contract does not include specific prescription drug pricing terms like a self-insured contract, so an audit of the prescription drug claim adjudication would not be measured against financial guarantees in the contract.

2) The proposed bill requires that the contract terms between the carrier (SHP) and the PBM (OptumRx) are provided to the Board. SHP may not be willing to provide this information on the basis that NDPERS is not a party to the contract with OptumRx.

3) The proposed bill requires that claim level data be provided that shows the total dollars paid to the PBM by the carrier and the Board. SHP may not be willing to provide this information on the basis that NDPERS is not a party to the contract with OptumRx.

4) The proposed bill requires claim level detail that splits out reimbursement components to the pharmacies from the PBM. OptumRx may not be willing to provide this information on the basis that NDPERS is not a party to the contracts they have with network pharmacies.

5) The proposed bill requires an accounting and explanation of any recoupments made by the PBM from the pharmacies. OptumRx may not be willing to provide this information on the basis that NDPERS is not a party to the contracts they have with network pharmacies.

6) The proposed bill requires a review of medical prescription drug claim rebates at the national drug code level and verify who retained the rebates for such drugs. Medical drug rebates may be contracted, collected, and administered by the carrier rather than the PBM and it is unclear if the proposed bill would require an audit of the carrier in addition to the PBM.

7) The provisions of the proposed bill were not included in the procurement for health insurance services for the biennium staring 7/1/2021. SHP and/or OptumRx may object to the requirements.

Senate Human Services Committee

State of North Dakota

Madam Chair Judy Lee and Committee Members

Re: HB 1233

March 16, 2021

Madam Chair Lee and Committee Members:

My name is Gary Boehler, a pharmacist registered in North Dakota. I have been a pharmacist for 51 years and have had much focus on pharmacy benefit managers and how they impact the costs of prescription drugs over the past 35 years. To sum it up, I have learned a lot.

My past experiences and current work includes a 34 year role with Thrifty White Drug being in middle and upper management positions prior to my retirement there in 2011. Since then, and as a consultant, I confer with pharmacies all over the country, work on anticompetitive issues with the Federal Trade Commission in Washington, D.C. and correspond with several state attorneys general across the country who are clearly interested in learning more about PBMs and their heinous activities. I consult for some 500 pharmacies in the Upper Midwest states on an as needed basis, the majority of it having to do with PBMs, their contracts, reimbursements, and recoupment fees. I also do some consulting with plan sponsors to help them through the "mine fields" many of them endure with their PBM contracts.

I am in full support of HB 1233 as I believe passing this bill with the ensuing audit language will clearly delineate what I have come to strongly believe will show, in this instance, how North Dakota taxpayer dollars have been and continue to be wasted and those dollars being pulled out of the state of North Dakota and simply used to enrich the PBMs, their vertically integrated subsidiaries, and shareholders, and all of this at the expense of patients, plan sponsors, and taxpayers.

My focus in today's testimony will focus on taxpayer funded prescription drug plans only and below I am listing various states' activities around the country that show the flagrant abuse and huge overcharges by PBMs that impact each and every one of us paying taxes. Here are examples:

Ohio – David Yost, state attorney general for Ohio, uncovered ***$225 million*** in spread pricing by two PBMs. Now, the state has moved over to a lesser known PBM, Gainswell, which has no apparent conflicts of interest by not owning mail order or specialty pharmacies by which they might compete with the state of Ohio.

Ohio – in another lawsuit just filed, Mr. Yost filed suit against Centene, another PBM doing managed care Medicaid in Ohio that used Envolve Pharmacy Solution and their apparent use of networks of subcontractors to provide prescription drug benefits in order to misrepresent pharmacy costs and therefore artificially inflate fees to the state of Ohio. Much more to follow, but another example.

Kentucky – uncovered ***$123 million*** in spread pricing for its Medicaid system in 2018.

North Dakota –per Brendan Joyce's report that was just released some weeks back, this small state will save ***$17 million*** in spread pricing fees after OptumRx was removed from managed care Medicaid January 1, 2020. And those savings are BEFORE any other administrative fees incurred. Those taxpayer funded savings stay right here in North Dakota and are not being shipped off to another state.

West Virginia – beginning in 2018 this state began saving ***$30 million*** per year in spread pricing fees.

Tennessee - has recovered in excess of ***$150 million*** in overcharges by PBMs.

Louisiana – has formed its own "PBM" of sorts to administer its own Medicaid claims. North Dakota has basically done the same thing, but one can only surmise what the savings might be were in the near future North Dakota do the same program for NDPERS. Louisiana saw the light and reacted wisely.

California – this state is on top in the United States for Medicaid recipients (18 million) Effective April 1, 2021, California is carving out all PBMs from their managed care programs, a bullet proof condemnation of what PBMS have been taking advantage of in that state as well, as well as others with changes done.

Georgia – this state has enacted a 'no spread pricing reimbursement" model wherein PBMs simply get a flat fee per prescription. One would only then assume a 100% pass through on manufacturer rebates, but I have no knowledge of what the flat fee per prescription entails. Georgia has "cut" the gravy from PBMs!

Illinois – this session of the IL legislature is looking at removing PBMs from managed care Medicaid. The average gross profit per prescription today per sources I have is $0.89 and that is before any costs of doing business are calculated. Spread pricing numbers are also being pursued.

Florida – has calculated that for every prescription filled for its Medicaid recipients, the average spread per prescription is $8.64, which is equal to 9.5% of total plan spend for that state. On December 8, 2020 the Florida Pharmacy Association estimated ***$113 million*** in markups (spread pricing) by PBMs.

Ohio – the state of Ohio has filed a lawsuit against **OptumRx** with regards to the state's Worker's Compensation program. According to Ohio's attorney general, OptumRx billed the state far in excess of what was detailed in the contract the state had with **OptumRx**. The state did not renew its contract with

OptumRx in 2018. The lawsuit will likely be well in excess of $***20 million*** based on the attorney general's allegations.

New York – early estimates on **PBM spread pricing** for NY state Medicaid recipients is ***$300 million***.

In May of 2016 the state realized a 10% spread price on just generics. During the fourth quarter of 2017, spread was found on 39% of all generic claims, averaging $5.62 per claim. Note that does not include numbers for brand name drugs! New York also discovered that from Q1 of 2016 through Q4 of 2017, PBMs cut the reimbursements to pharmacies by 83%, resulting in an average gross margin per prescription of $0.53. In the fourth quarter of 2017 50% of the PBM spread pricing came from just 6% of the dispensed generic drug claims. The same can be said for claims being reimbursed by **OptumRx** for NDPERS prescription claims. Percentages may vary, but the trend is there and can be substantiated. I find it extremely interesting that OptumRx hides behind Sanford Health vs. direct contracting with NDPERS one on one. It should create flags about what is really happening, and it has. Watch for the following salvos!

I am also attaching to this testimony some examples showing how **OptumRx** and **Express Scripts** are fleecing our senior citizens who are on Medicare Part D by marking up generic drugs enormously, then charging these patients an astronomical copay, which in reality is nothing more than a patient clawback. This comes to me from a pharmacy in Iowa, but if it is happening in Iowa, it is happening in North Dakota as well.

All of the examples I have shown make it very clear the audit language in HB1233 needs full bipartisan support to end these transgressions, at least for the state of North Dakota, and its well-known reputation for "taking care of its own."

Thank you for allowing me to provide this testimony on HB 1233. I can always be reached with further questions. My contact information is shown below.

Sincerely,

Gary W. Boehler, R.Ph.

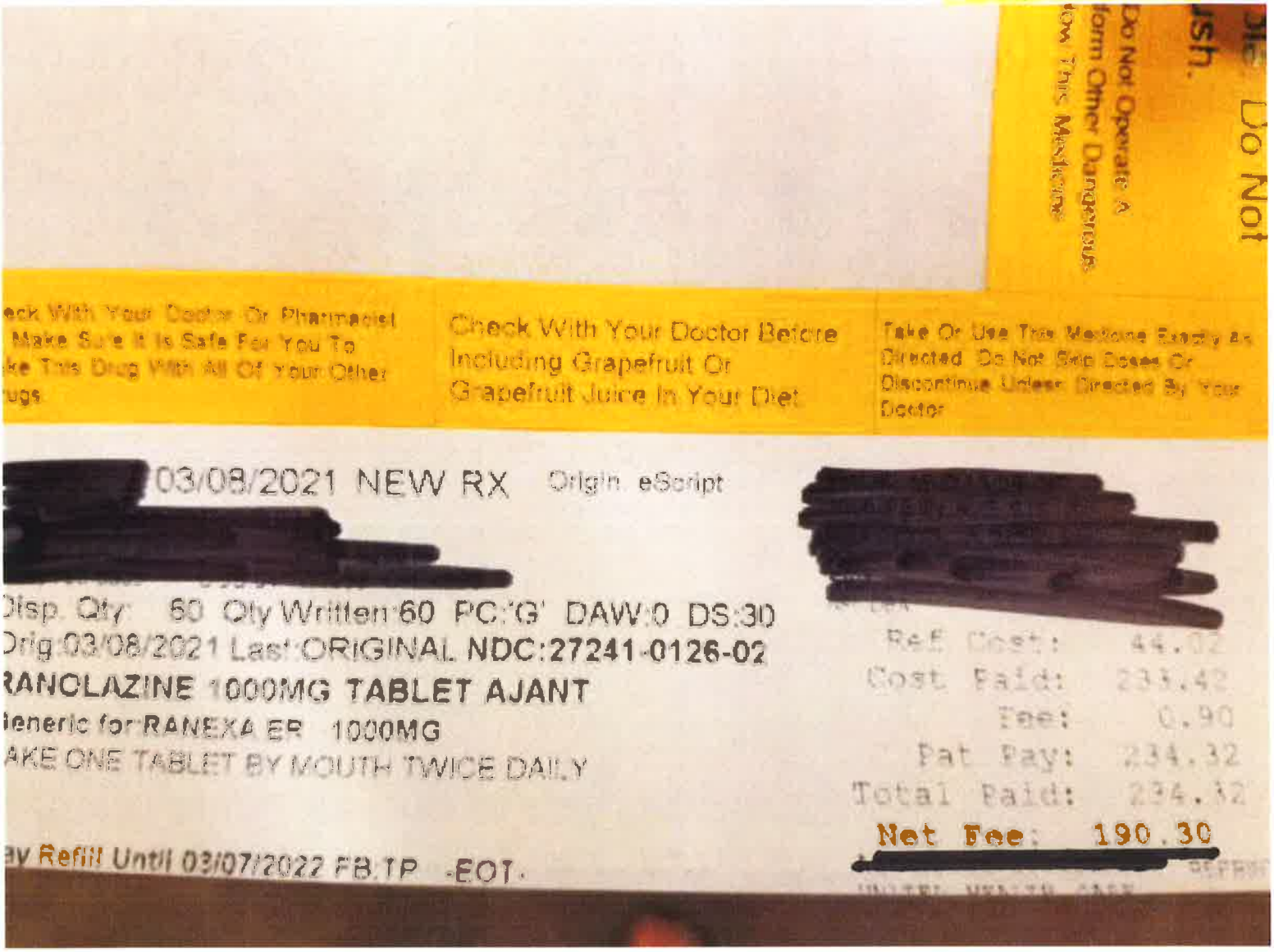
Pharmacist Consultant

gboehler@dakdrug.com or pilrlr@comcast.net

(800) 437-2018*6210

Cell: 763.354.4875

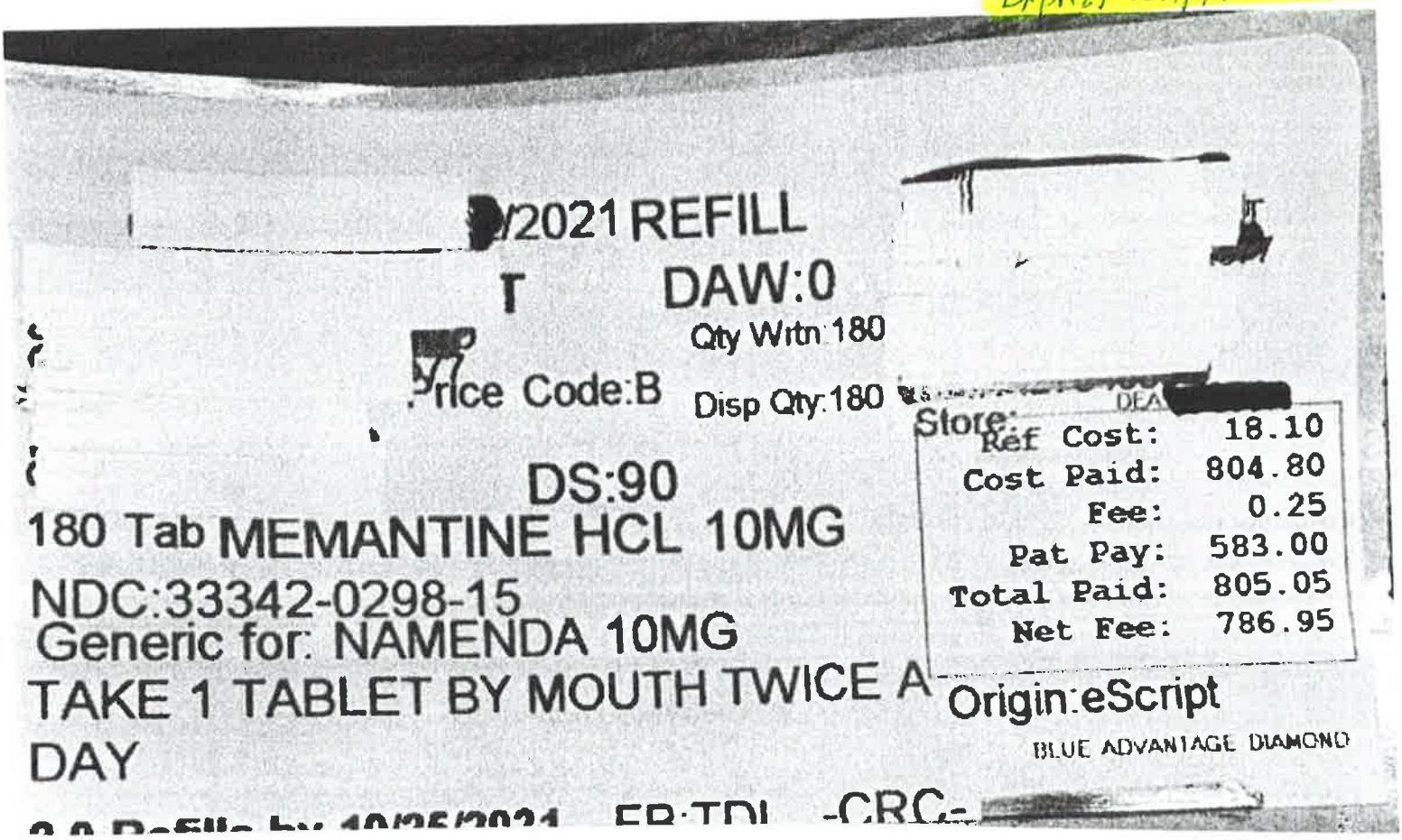
OPTUM Rx - Part D Patient



- This drug is a generic.
- Cost is $22.44 per 60 ct. bottle. ($0.374/dose)
- PBM (Optum Rx) is charging patient $234.32 ($3.905/dose) ($7.81/day)
- Optum Rx is "marking" up patient copay 629.2 times.
- A typical cash price in a pharmacy would be ~$35.00, or $0.583/dose
- Then, retrospectively, the pharmacy can fully expect a DIR recoupment of at least 40% or $93.73.
- This is nothing more than a classic example of a patient clawback by Optum Rx @ the point of sale.

POOR PATIENT! Gary

Medicare
Express Scripts - Part D



- This drug is a generic.
- Cost is $21.17 per 500 ct bottle ($0.042 per dose)
- PBM (Express Scripts) is charging patient $583.00 ($3.24/dose, $6.48/day)
- Express Scripts is "marking up" patient copay 13,881 times.
- A typical cash price in a pharmacy would be ≈ $20.00 ($0.11/dose)
- Then, retrospectively the pharmacy can expect a DIR recoupment of at least 40%, or $321.92.
- Another classic example of an Express Scripts patient clawback at the point of sale. POOR PATIENT!
- I have filed a formal complaint with CMS and am awaiting a response from Blue Cross/Blue Shield Tennessee and Express Scripts.

Gary

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1233
3/17/2021 PM

A BILL for an Act to amend and reenact section 54-52.1-04.16 of the North Dakota Century Code, relating to public employees retirement system prescription drug coverage performance audits.

Madam Chair Lee opened the discussion on HB 1233 at 2:30 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Proposed amendment
- Failure to perform audits
- Pharmacy benefit manager contracts
- Two-year contract renewals
- Retroactive audits

[2:31] Senator Judy Lee, District 13. Provided the committee with an overview of proposed amendment 21.0147.02001 (testimony #9809)

Senator Anderson moves to **ADOPT AMENDMENT** 21.0147.02001
Senator Clemens seconded.

Voice Vote – Motion passed

Senator Anderson moves **DO PASS, AS AMENDED, REREFER TO APPROPRIATIONS.**
Senator Hogan seconded.

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	N
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Oley Larsen	Y

The motion passed 5-1-0
Senator Anderson will carry HB 1233.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1233 at 2:51 p.m.

Justin Velez, Committee Clerk

21.0147.02001
Title.03000

Prepared by the Legislative Council staff for
Representative Kasper
March 16, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1233

Page 4, line 4, after "implemented" insert ".

g. A document or information provided to the board or the auditor under this section is confidential commercial information and a trade secret, is exempt from public inspection, and is not a public record under section 44-04-18. A document or information provided to the board or the auditor under this section and the performance audit report prepared under this section may not be released to another person in a manner that allows for the identification of an individual drug or manufacturer or in a manner that has the potential to compromise the financial, competitive, or proprietary nature of the information"

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1233, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed HB 1233 was placed on the Sixth order on the calendar.

Page 4, line 4, after "implemented" insert ".

g. A document or information provided to the board or the auditor under this section is confidential commercial information and a trade secret, is exempt from public inspection, and is not a public record under section 44-04-18. A document or information provided to the board or the auditor under this section and the performance audit report prepared under this section may not be released to another person in a manner that allows for the identification of an individual drug or manufacturer or in a manner that has the potential to compromise the financial, competitive, or proprietary nature of the information"

Renumber accordingly

21.0147.02001
Title.

Prepared by the Legislative Council staff for
Representative Kasper
March 16, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1233

Page 4, line 4, after "implemented" insert ".

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Renumber accordingly

2021 SENATE APPROPRIATIONS

HB 1233

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1233
3/30/2021
Senate Appropriations Committee

Relating to public employees retirement system prescription drug coverage performance audits.

Senator Holmberg opened the hearing at 11:15 am.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- PBM

Jim Kasper, Representative, District 46, introduced the bill; testimony #11056.

Scott Miller, PERS, testified in opposition #10995

Mike Schwab, testified in favor

Additional written testimony in favor: #10929, #10925, #10938

Senator Holmberg closed the hearing at 11:56 a.m.

Skyler Strand, Committee Clerk

54-52.1-04.15. Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

1. If the prescription drug coverage component of a health insurance benefits coverage contract received in response to a request for bids under section 54-52.1-04 utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, in addition to the factors set forth under section 54-52.1-04 the board shall consider and give preference to an insurer's contract that:
   a. Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefits management company which controls the prescriptions drug coverage offered as part of the health insurance benefits coverage, and if the contract is revised or a new contract is entered, requires the insurer to provide the board with the revision or new contract within thirty days of the change.
   b. Provides the board with monthly claims data and information on all programs being implemented or modified, including prior authorization, step therapy, mandatory use of generic drugs, or quantity limits.
   c. Describes the extent to which the board may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are covered; the formulary; and the member programs implemented.
   d. Describes the audit rights of the board.
2. The board may conduct annual audits to the extent permitted under the contract terms agreed to under subsection 1. The audits must include:
   a. A review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.
   b. A review of a list of all programs that have been implemented or modified during the audit period under subsection 1, and in connection with each program the auditor shall report on the cost, the cost savings or avoidance, member disruption, the process for and number of overrides or approvals and disapprovals, and clinical outcomes.
   c. Recommendations for proposed changes to the prescription drug benefit programs to decrease costs and improve plan beneficiaries' health care treatment.
3. Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts.
4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager; a pharmaceutical manufacturer representative; or any retail, mail, or specialty drug pharmacy representative or vendor.

54-52.1-04.16. Prescription drug coverage - Performance audits.

1. Except for Medicare part D, prescription drug coverage, the board may not enter or renew a contract for prescription drug coverage unless the contract authorizes the board during the term of the contract to conduct a performance audit of the prescription drug coverage and any related pharmacy benefits management services. The contract must provide:
   a. The board must have full access to data regarding:
      (1) The total dollars paid to the pharmacy benefits manager by the carrier and the board;
      (2) The total amount of dollars paid to the pharmacy benefits manager by the carrier which were not subsequently paid to a licensed pharmacy in the state; and
      (3) Payments made to all pharmacy providers.
   b. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy

benefits manager to licensed pharmacies with which the pharmacy benefits manager shares common ownership or control or is affiliated.

c. The board must have full access to data regarding the average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefits manager to pharmacies licensed in the state.

d. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager on pharmacies licensed with which the pharmacy benefits manager shares common ownership or control or is affiliated.

e. The board must have full access to data regarding any direct and indirect fees, charges, or recoupment, or any kind of assessments imposed by the pharmacy benefits manager, on pharmacies licensed in the state.

f. The contract must provide that all drug rebates, financial incentives, fees, and discounts must be disclosed to the board.

2. The board shall use an independent auditor who has no conflict of interest with the carrier, pharmacy benefits manager, or board. The board's auditor, the insurance department, and the employee benefits programs committee may access any information the board may access under this section. All information accessed by the board, board's auditor, insurance department, or employee benefits programs committee which is trade secret is a confidential record. This subsection does not limit the information required to be disclosed to the board under subsection 1.

3. If the board contracts directly with a pharmacy benefits manager or provides prescription drug coverage through a self-insurance plan, the contract must provide the pharmacy benefits manager shall disclose to the board and the board's auditor all rebates and any other fees that provide the pharmacy benefits manager with sources of income under the contract, including under related contracts the pharmacy benefits manager has with third parties, such as drug manufacturers.

4. Anything the board has access to under this section, the insurance department and employee benefits programs committee has access to.

54-52.1-04.17. Self-insurance health plan - Bank of North Dakota line of credit - Continuing appropriation.

The Bank of North Dakota shall extend to the board a line of credit not to exceed fifty million dollars. The board shall repay the line of credit from health insurance premium revenue or repay the line of credit from other funds appropriated by the legislative assembly. The board may access the line of credit to the extent necessary to provide adequate claims payment funds, to purchase stop-loss coverage, and to defray other expenditures of administration of the self-insurance health plan. All loan funds received by the board from the Bank under this section, not otherwise appropriated, are appropriated to the board for the repayment of claims and other costs of the uniform group insurance program.

54-52.1-05. Provisions of contract - Term of contract.

1. Each uniform group insurance contract entered by the board must be consistent with the provisions of this chapter, must be signed for the state of North Dakota by the chairman of the board, and must include the following:
   a. As many optional coverages as deemed feasible and advantageous by the board.
   b. A detailed statement of benefits offered, including maximum limitations and exclusions, and such other provisions as the board may deem necessary or desirable.
2. The initial term or the renewal term of a uniform group insurance contract through a contract for insurance, health maintenance organization, or self-insurance health plan for hospital benefits coverage, medical benefits coverage, or prescription drug benefits coverage may not exceed two years.
   a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations, the proposed premium

CHAPTER 54-52.1
UNIFORM GROUP INSURANCE PROGRAM

54-52.1-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board" means the public employees retirement board.
2. "Carrier" means:
   a. For the hospital benefits coverage, an insurance company authorized to do business in the state, or a nonprofit hospital service association, or a prepaid group practice hospital care plan authorized to do business in the state, or the state if a self-insurance health plan is used for providing hospital benefits coverage.
   b. For the medical benefits coverage, an insurance company authorized to do business in the state, or a nonprofit medical service association, or a prepaid group practice medical care plan authorized to do business in the state, or the state if a self-insurance health plan is used for providing medical benefits coverage.
   c. For the life insurance benefits coverage, an insurance company authorized to do business in the state.
3. "Department, board, or agency" means the departments, boards, agencies, or associations of this state. The term includes the state's charitable, penal, and higher educational institutions; the Bank of North Dakota; the state mill and elevator association; and counties, cities, district health units, and school districts.
4. "Eligible employee" means every permanent employee who is employed by a governmental unit, as that term is defined in section 54-52-01. "Eligible employee" includes members of the legislative assembly, judges of the supreme court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by section 54-06-01, and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund. As used in this subsection, "permanent employee" means one whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. For purposes of sections 54-52.1-04.1, 54-52.1-04.7, 54-52.1-04.8, and 54-52.1-11, "eligible employee" includes retired and terminated employees who remain eligible to participate in the uniform group insurance program pursuant to applicable state or federal law.
5. "Health insurance benefits coverage" means hospital benefits coverage or medical benefits coverage, or both.
6. "Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter 26.1-18.1.
7. "Hospital benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for hospital services incurred in accordance with the uniform contract.
8. "Life insurance benefits coverage" means a plan that provides both term life insurance and accidental death and dismemberment insurance in amounts determined by the board, with a minimum of one thousand dollars provided for the term life insurance portion of the coverage.
9. "Medical benefits coverage" means a plan that either provides coverage for, or pays, or reimburses expenses for medical services in accordance with the uniform contract.
10. "Member contribution" means the payment by the member into the retiree health benefits fund pursuant to sections 54-52-02.9 and 54-52-17.4.
11. "Member's account balance" means the member's contributions plus interest at the rate set by the board.

Jim Kasper

From: Clark, Jennifer S. <jclark@nd.gov>
Sent: Friday, February 12, 2021 12:31 PM
To: Kasper, Jim M.; Jim Kasper
Subject: HB 1233

Good Afternoon-

Per your request, here is a link to NDCC Chapter 54-52.1, the law relating to PERS uniform group insurance, and here is a link specifically to Section 54-52.1-04.16, the law providing for pharmacy benefits performance audits.

Under Section 54-52.1-04.16, there are three main provisions – subsections 1, 2, and 3.

- Subsection 1 provides PERS may not enter or renew a contract for prescription drug coverage unless the contract authorizes PERS to conduct a performance audit.
- Subsection 2 directs PERS to use an independent auditor in performing a performance audit.
- Subsection 3 provides if PERS contracts directly with a PBM or provides pharmacy benefits through self-insurance, the contract must provide the PBM shall disclose all rebates and other fees that provide the PBM with sources of income.

An observation of mine, although the law provides the contract provisions must provide access for an audit and that the PBM must disclose all drub rebates and fees, the law does not expressly direct PERS to conduct the audit. I would be interested to know whether PERS is conducting the audit they have the authority to conduct.

Iope this information helps-

Jenn

Jennifer Clark
Senior Legal Counsel
jclark@nd.gov
701.328.2916

Kasper, Jim M.

From: Miller, Scott A.
Sent: Monday, March 29, 2021 2:19 PM
To: Kasper, Jim M.
Subject: RE: SHP Agreement/Audit Language--MONDAY MARCH 29, 2021---ATTACHED CONTRACT WITH SANFORD

Representative Kasper –

I apologize if it appears like I am playing games. That is not my intent.

Section 11.2 of the contract with SHP specifically incorporates the State's RFP and SHP's proposal in response to the RFP into the contract. As I stated, that is a common way to incorporate RFP requirements and vendor agreements and concessions into an agreement.

Pages 18-19 of the RFP specifically requires compliance with NDCC sec. 54-52.1-04.16. Question 1112 of the RFP also asked the vendors to respond to whether their proposal complies with NDCC sec. 54-52.1-04.16, to which SHP replied in the affirmative: "The proposal complies with 54-52.1-04.16 by providing the board with full access to the specified data."

Question 1113 of the RFP asked the vendors whether there are any requirements of NDCC chapter 54-52.1 that they could not meet, and why. Again, SHP responded affirmatively that, "Sanford Health Plan can meet all areas of 54-52.1 as specified above."

Because section 11.2 of the contract with SHP specifically incorporates the NDCC sec. 54-52.1-04.16 requirement and SHP's affirmative responses into the agreement, the answer to your question of where in the contract it gives NDPERS the right to conduct an audit under 54-52.1-04.16 is section 11.2 of the agreement.

I provided screen shots of the above portions of the relevant documents, which you can see below.

Scott

Scott A. Miller
Executive Director
North Dakota Public Employees Retirement System

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Kasper, Jim M.

From: Miller, Scott A.
Sent: Sunday, March 14, 2021 4:24 PM
To: Kasper, Jim M.; Jim Kasper
Subject: RE: Information Request---FISCAL NOTE ON HB 1233---FROM REP. JIM KASPER--SATURDAY MARCH 13, 2021
Attachments: 21.0147 (HB1233)_PBM Audit_Deloitte Memo_03.01.21.pdf

Good Afternoon, Representative Kasper –

I have attached Deloitte's analysis of the current version of HB 1233. As you can see, they maintain that the audit requirements within HB 1233 remain so broad that they will encompass parts or all of five different "typical" PBM audits. They provided information on what they believe is an accurate range of the market price for each of those types of audits. As with our initial fiscal note, we took the minimum from that range for each of the audits and added them together to get the $375,000 figure. Since you did take out the audit requirements for our Part D providers, we eliminated the cost of auditing two additional providers. So the fiscal note went from $1,125,000 to $375,000.

You had also asked for information on the State's health plan premium spend, and the specific premium paid, for the past five bienniums. That information is below:

IDPERS State Health Plan Premiums

Biennium	Monthly State Premium	Biennium Total Premium	
2019-21*	$1,426.74	$495,238,575	* Estimated
2017-19	$1,240.82	$429,581,811	
2015-17	$1,130.22	$411,419,294	
2013-15	$981.68	$361,669,564	
2011-13	$886.62	$323,497,493	
2009-11	$825.66	$298,066,563	

You had also asked for some information on our deferred compensation and flex-comp programs, which is below.

Deferred Compensation Participating Employer Count	
City	51
County	30
District Health Unit	15
Other Political Subdivisions	38
School District	31
State	98
	263

Delete ···

RE: NEED HELP==AUDITS BY OTHER STATES ON PBMS

GB

Gary Boehler
Wed 2/24/2021 8:13 AM
To: Kasper, Jim M.

Gary Boehler R Ph .vcf
4 KB

***** **CAUTION:** This email originated from an outside source. Do not click links or open attachments unless you know they are safe. *****

Jim,

Here is the shortened version; all are Medicaid related unless I specify otherwise. Hope this helps.

1. Ohio – Medicaid spread pricing of $224 million
2. New York – spread pricing of approximately $300 million
3. North Dakota - $17 million in savings over the biennium
4. Kentucky - $123.5 million in spread pricing
5. Florida - $89 million in spread pricing
6. Michigan - $64 million in spread pricing
7. Pennsylvania – from 2013 to 2017 Medicaid spending more than doubled from $1.41 billion to $2.86 billion. Spread pricing being investigated.
8. Ohio – Bureau of Worker's Compensation - $15.8 million in overcharges.
9. Ohio – Highway Patrol Retirement System being investigated for ESI not following plan guarantees – millions of dollars at stake.
10. Florida – discovered that PBM specialty pharmacies only dispensed 0.4% of prescriptions BUT collected more than 28% of the profits – a perfect example of doing nothing for $$$$$$ in their pockets. Typical middleman game.

This should send the message.

Gary

Gary Boehler, R.Ph.
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Pharmacist Consultant

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1101 Lund Boulevard
Anoka, MN 55303

From: Kasper, Jim M. [mailto:jkasper@nd.gov]
Sent: Tuesday, February 23, 2021 5:12 PM

TESTIMONY OF SCOTT MILLER

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in opposition to House Bill 1233.

The first question I would like to address is this: "What will House Bill 1233 ***NOT*** do?"

HB 1233 will NOT affect whether Pharmacy Benefit Managers (PBMs) pay pharmacies below Medicaid rates – there is nothing in this bill that requires any level of reimbursement. Further, the Medicaid rates do not take into account incentives and rebates offered to the pharmacy, and as a result, this reimbursement is higher than traditional commercial rates. Sanford Health Plan did a re-pricing of our pharmacy benefits using Medicaid rates, and if that were required, our pharmacy spend would go up $8 million per year. But this bill does not require that.

HB 1233 will NOT put an end to "spread pricing" – there is nothing in this bill that affects whether spread pricing is taking place anywhere in the state. While spread pricing may indeed be onerous or insidious, spread pricing is a legal practice that takes place in many fully insured plans. It is NOT permitted in some Medicaid plans, and that is from where many of the examples you heard of hundreds of millions of dollars of recoveries through audits come. We are not a Medicaid plan.

HB 1233 will NOT affect whether a PBM encourages a participant to acquire their drugs through mail order – there is nothing in this bill that addresses that issue at all.

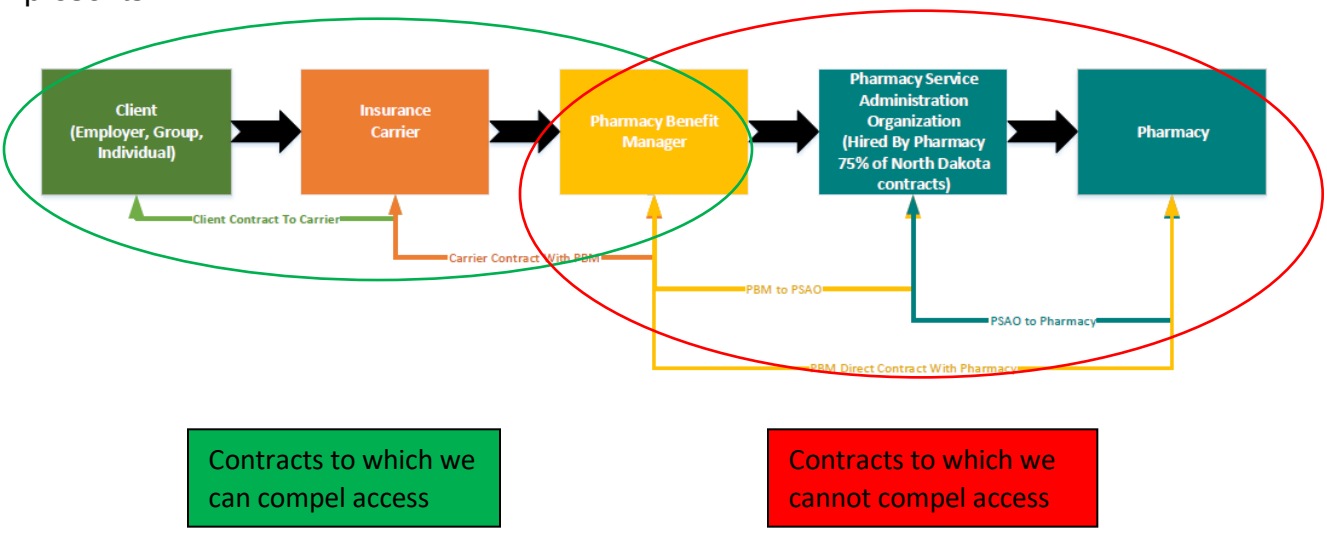
HB 1233 will NOT affect whether a local pharmacy can deliver specialty drugs – there is nothing in this bill that addresses that issue at all. In fact, NDCC section 19-02.1-16.2(5) states, "A licensed pharmacy or pharmacist may dispense any and all drugs allowed under that license." State law already clearly states that local pharmacies can deliver specialty drugs.

HB 1233 will NOT affect the contractual rights and responsibilities between our PBM, OptumRx, and the underlying pharmacies or PSAOs, or the contracts between the pharmacies and their PSAOs – the terms of

those agreements are the responsibility of the contracting parties, not NDPERS. If they agreed to audits or clawbacks or a certain level of reimbursement, this bill will not affect those contractual provisions. This is not a "fairness" bill, this is a forced audit bill.

Of course, that leaves the question about what House Bill 1233 actually does. In a nutshell, House Bill 1233 requires the NDPERS Board to conduct audits that will be difficult if not impossible to perform, and require contractual provisions with future PBMs that may result in increased premiums for pharmacy benefits, if not the complete elimination of our pharmacy plan. This bill requires NDPERS to perform audits of the performance of contractual responsibilities for contracts to which we are not parties and to which we cannot require access. This bill also requires any contract with a PBM to include the PBM's agreement to allow a performance audit that includes an audit of the performance of contracts that the PBM does not have the unilateral authority to disclose.

The below graph will help me explain the problems, and the impossibilities, this bill presents.



In this graph, NDPERS is in the green box to the left – we are the client. We contract with Sanford Health Plan (SHP) for both our medical benefits and our pharmacy benefits – SHP is in the orange box above, second from the left. SHP does not directly provide the pharmacy benefits. Instead, SHP contracts with a PBM, OptumRx, to provide those services. The PBM is in the middle yellow box above. From a practical perspective, since we have a fully-insured plan, these are the only contracts we are concerned with. We have a vested interest that SHP is providing prescription benefits in the manner to which they have committed in our contract with them, and so the performance of the PBM in regard to its contract with SHP is something into which we can arguably inquire.

Pharmacy service administration organizations (PSAOs) are in the second box from the right, and pharmacies are in the far right box. For your information, a PSAO is an entity that contracts with a pharmacy to assist with third-party payer interactions and administrative services related to third-party payer interactions. Basically they help pharmacies contract with PBMs, or serve as an intermediary between a pharmacy and a PBM. Approximately 75% of pharmacies in North Dakota use PSAOs.

Contracts between PBMs and PSAOs have strict confidentiality requirements built into them – both parties must consent before either party can share those contracts. Similarly, contracts between PBMs and pharmacies have strict confidentiality requirements – both parties must consent before either party can share those contracts. Finally, contracts between PSAOs and pharmacies have strict confidentiality requirements – again, both parties must consent before either party can share those contracts. You can see that in the red oval to the right – we cannot compel the parties to share those contracts, for an audit or any other purpose.

How can we force those entities to share their contracts with us in order for us to audit the performance of those contracts? How can we require a PBM to commit to getting us access to those contracts before we contract with them, when that PBM cannot share those contracts without the PSAO's or the pharmacy's consent?

That's the biggest problem with HB 1233 – even though we have no legal right to require the parties to provide us with the contracts between our PBM and any PSAOs or pharmacies, or between the pharmacies and the PSAOs, this bill requires us to audit certain performance under those contracts. Further, and equally problematic, this bill requires us to put in any contract with a PBM that we must have the right to audit the performance of these contracts. Contracts we do not have a right to see.

How can we do that? How can we force a PBM to provide us access to contracts that the PBM does not control? What will that do to competition for our business?

The below list of new audit requirements shows which requirement applies to which contract:

Page 1, lines 22-24: NDPERS and SHP; SHP and OptumRx

Page 2, lines 1-3: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 4-6: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 7-8: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 9-13: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 14-17: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 18-23: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 24-27: OptumRx and PSAOs/pharmacies; PSAOs and pharmacies

Page 2, lines 28-29: SHP and OptumRx

Page 2, lines 30-31: SHP and OptumRx

Page 3, lines 2-6: NDPERS and SHP

Page 3, lines 7-16: NDPERS and SHP; SHP and OptumRx

Page 3, lines 17-22: SHP and OptumRx

Page 3, lines 23-25: NDPERS and SHP

Page 4, lines 1-4: SHP and OptumRx

The underlined sections above require us to audit contracts to which we have no legal right to require access, much less audit.

NDPERS does, of course, have a significant interest in how OptumRx provides benefits to our participants. If NDPERS has a problem with our pharmacy benefits, we go directly to SHP, and may even involve OptumRx – in fact, we required OptumRx to appear before the Board some time ago to explain some issues we were having.

But NDPERS has no right to get involved in the relationship between OptumRX and the PSAOs or pharmacies. And certainly no right to get involved in the relationship between the PSAOs and the pharmacies. However, House Bill 1233 would require us to audit many aspects of the performance of those contracts. NDPERS believes that is requiring us to do something that is neither our concern nor something that is possible for us to do. Because of that, we have to oppose House Bill 1233.

If our health plan was self-funded, we may be more interested. But we are not self-funded – we have a modified fully insured health and pharmacy benefits plan. We are concerned about claims made to and claims paid by SHP and OptumRx. HB 1233 would require us to reach much further into the stream of commerce, into places we arguably have no right to go.

And remember, since this is a modified fully insured plan, we have none of the risk – Sanford Health Plan has all of the risk. But we get part of the gain – we get 50% of the gain up to $3 million, and all of the gain above that. SHP has a vested, monetary interest in ensuring our PBM is performing according to contract. SHP is currently spending their own money to regularly audit the PBM. HB 1233 will require us to use the State's money, our insurance reserves, to conduct audits that SHP is already conducting (other than the broader contract issues I have mentioned), and which will most likely benefit SHP well before it benefits NDPERS and the state.

One of the arguments made on the House Floor in favor of HB 1233 is that there is a threat that our contract with SHP and their contract with OptumRx may involve what is called "spread pricing". Spread pricing is common in "traditional" PBM contracts that are part of fully-insured plans. The alternative is a "transparent" PBM contract, which is typically found in self-insured plans. The agreement with OptumRx is, in fact, a transparent PBM contract, and is part of our modified fully-insured plan. NDCC section 54-52.1-04.16 already provides us the audit authority we need in order to be assured that spread pricing is not taking place.

The potential cost is another significant concern about House Bill 1233. I do not mean just the minimum $375,000 we will spend on the audits (or attempt to spend, since we most likely will not be successful in auditing all of what HB 1233 requires). If House Bill 1233 were to pass, we have concerns that we will not receive bids for our pharmacy benefit plan in the future, and, if we do, what the cost of that plan would be.

NDCC section 54-52.1-04.16 was originally created just last session – it is the codification of House Bill 1374 from the 2019 Legislative Assembly. When enacted, section 54-52.1-04.16 greatly expanded the audit requirements that NDPERS had to put in any contract for PBM services, including if we obtained those PBM services through a health insurance carrier like SHP.

The audit requirements imposed by section 54-52.1-04.16 are much more broad than are typically found in a fully-insured arrangement. With most fully-insured plans, you pay a given amount for coverage, and they cover it, regardless of the cost.

Section 54-52.1-04.16 imposes audit requirements that go far beyond that. Those expanded audit requirements have already had an impact on competition for our plan; in their initial proposal, one of the vendors responded that it could not commit to complying with section 54-52.1-04.16. That vendor only changed its response when we reminded them that it was a minimum qualification, and that their proposal would be deemed non-responsive if they could not commit to complying with that statute.

House Bill 1233 expands the breadth of auditing requirements well beyond that currently found in statute. If we had problems with that statute as it currently reads, we

are seriously concerned about the problems we will have obtaining pharmacy benefits for our employees under the greatly expanded requirements from House Bill 1233.

Even if we do receive bids for the plan, the requirements of 54-52.1-04.16 will necessitate that all bids are transparent in nature. During our bid process last year, we received bids from three "transparent" PBMs (other than OptumRx through the SHP contract). If we were required to use the least expensive of those other PBMs, the state's premiums would have gone up another 5%, or nearly $32 million. Given that our total prescription drug spend for a biennium is just over $100 million, that is a 32% increase in our pharmacy cost.

Further, the bill provides no alternatives for NDPERS if no party is willing to add these provisions. If NDPERS is not able to add this to its fully insured contract with SHP, which was just bid this last fall, does NDPERS need to rebid? If so, since there is not time to do a full rebid before the beginning of the next biennium, should NDPERS extend the existing contract until a new bid can be completed with the new minimum requirements? If NDPERS is not able to contract for these services with these minimum requirements with a PBM, then is it the intent of the bill that NDPERS would not provide prescription drug services to our members? Could you imagine what that would do to the state's ability to recruit and retain employees? Or would NDPERS have the authority to sign a contract with a PBM that met "most" of the requirements? We previously asked for this guidance, and have not yet received it. Accordingly, NDPERS must oppose House Bill 1233.

I would also again point out that the audit provisions in the current version of NDCC section 54-52.1-04.16 were just added last session – it became effective on August 1, 2019. The PBM we use, OptumRx, just began providing us services on January 1, 2019. There would have been almost nothing to audit once the statute became effective.

In January of 2020, we began the RFP process for our health and pharmacy benefits plan. With the potential of changing carriers as a result of the RFP, there was little reason to spend the money to audit a PBM that had only been providing us services for one calendar year and that we may replace for the next biennium. However, now that OptumRx has been providing PBM services to us for over two years, and we have awarded the new contract to SHP, which includes the required statutory language passed last session in HB 1374, this is a reasonable time to engage in an audit under the current parameters of NDCC 54-52.1-04.16. Those audit requirements are in the 2021-23 contract with SHP right now; the expanded audit requirements in HB 1233 are <u>not</u>, and may be difficult, if not impossible, to add. We would propose doing an audit under the current statute over the upcoming interim and presenting that information to the Employee Benefits Programs Committee. If the Legislative Assembly believes that

audit is incomplete for any reason, it could easily add what it wants during the next session.

At the end of the day, the Legislative Assembly needs to make the policy decision regarding whether it intends to change the NDPERS RFP award process requirement of selecting the lowest cost, most beneficial bid, with the least financial risk to the state, that best meets the overall requirements. If the Legislative Assembly would like the NDPERS Board to continue with that methodology, then this bill needs to fail. Alternatively, additional wording is needed in the bill. The following wording is one way to provide this clarification in the bill:

> At the end of the bill add:
>
> "Section 2: A new section is added to chapter 54-52.1
>
> The requirements in 54-52.1-04.16 do not apply if:
> 1. No bidder offers a proposal that complies with 54-52.1-04.16; or
> 2. The bid or bids that comply with 54-52.1-04.16 are more costly than those that do not comply."
>
> An alternative subsection 2 could be:
>
> 2. The bid or bids that comply with 54-52.1-04.16 are more than 1% higher than the lower cost proposal meeting the requirements."

Alternatively, NDPERS would strongly suggest adding a requirement into this statute that downstream parties to these contracts must share both the contracts and the relevant data with our auditors, under condition of maintaining the confidentiality. I have drafted a proposed amendment with this language, which is on the final page.

Summary

In recognition of the above, NDPERS would suggest the following:

1. Clearly specify if it is the intent for NDPERS to audit the performance of a contract to which we are not a party and cannot require access.
2. Since the bill establishes minimum requirements that were not a part of the bid specification for 2021-23, consideration should be given to making it applicable beginning with the 2023-25 contract period so it can become a part of the minimum requirement for that contract or, if necessary, a new bid process. If this is to be effective for 21-23, and since it was not a part of the scope of work in that bid, we will need to renegotiate the arrangement with the new specifications.

3. Provide direction in the bill on what NDPERS should do if it is unable to get a contract with these provisions for the active plan. Do we move forward without a pharmacy plan for our employees?
4. If NDPERS is unable to get these provisions added to our existing fully insured contracts, should NDPERS have to rebid the plan before the beginning of the next biennium? If so, then consideration should be given to allowing NDPERS to offer a no bid contract, or extending the existing arrangement until a new bid can be completed, since there would be insufficient time do a full bid. It should also be noted that if a new bid is done, rates could change, and if they go up, NDPERS would need to cut benefits so they match the premium, or subsidize the premium from reserves. Notably, if the premiums go up the $32 million I mentioned above, we will nearly wipe out our reserves. If the Legislature would like to provide guidance to the Board on this it could be added to this bill.
5. Or, if this bill is approved, add on the amendment I have provided on the last page.

We would also point out, again, that we already have very broad audit requirements in NDCC section 54-52.1-04.16 that the Legislative Assembly just passed last session. Last session, these broad audit requirements were apparently exactly what the Legislative Assembly wanted. We would suggest not passing this bill, giving NDPERS the opportunity to conduct an audit under the current requirements, and reviewing the results. If the Legislative Assembly does not see what it would like to see, it could address those deficiencies in the next session. There is no hurry. And haste may result in tens of millions of dollars of additional expenses, wiping out our reserves.

And remember, this bill will address none of the evils you heard about PBMs. This bill does not address spread pricing. This bill does not address reimbursement rates. This bill does not address specialty drugs or mail order drugs. This is an audit bill. This bill does none of those things.

In conclusion, I would have you ask yourself what do you think is the answer to the question: “How can a Pharmacy Benefit Manager commit to allowing audits of contracts that it is prohibited from sharing without someone else’s permission?” The answer is, it can’t. This bill requires an impossibility, and in so doing puts employee pharmacy coverage in jeopardy. The NDPERS Board urges this Committee to adopt a “do not pass” recommendation.

PROPOSED AMENDMENT TO ENGROSSED HOUSE BILL 1233

Page 4, after line 22, insert the following:

5. Pharmacies and pharmacy service administrative organizations that work with the pharmacy benefit manager subject to audit under this section shall share the relevant contracts and data with the board's contracted auditor for completion of this audit. If the contracts or data shared under this subsection contain confidential trade secret information, the contracts or data shared under this subsection retain their confidential status as provided in subdivision (3)(g), above.

Renumber accordingly.

TESTIMONY OF REBECCA FRICKE

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good morning, my name is Rebecca Fricke. I am the Chief Benefits Officer of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in opposition to House Bill 1233. I am available should there be any questions related to the impact of the bill on any of the NDPERS benefits.

TESTIMONY OF DERRICK HOHBEIN

House Bill 1233 – Pharmacy Benefit Manager Audit Requirement

Good afternoon, my name is Derrick Hohbein. I am the Chief Operating/Financial Officer of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in opposition to House Bill 1233. I am available should there be any questions related to the impact of the bill on any of the NDPERS benefits.

March 29, 2021

Daniel Weiss, Senior Executive Director, Pharmacy, Sanford Health Plan will be available to answer questions from the committee in support of Scott Miller, NDPERS.

Thank you.

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1233
4/1/2021
Senate Appropriations Committee

Relating to public employees retirement system prescription drug coverage performance audits.

Senator Holmberg opened the committee work at 8:02 AM.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- **Update on Bills and Sub-Committees**

Senator Poolman – gave an update on HB 1388.

Senator Erbele - gave an update Historical Society (HB 1018).

Senator Sorvaag – Game and Fish (HB 1017) update; HB 1020 – Water Commission update

Senator Hogue – gave update on WSI (HB 1021) sub-committee.

Senator Bekkedahl – gave update on RIO (HB 1022)

Senator Hogue updated the committee on (HB 1035) Uniform Juvenile Court Act.

HB 1233 – waiting for recommended amendment

HB 1246 – **Senator Rust** is waiting for an amendment – attaching the Air Force base to the bill.

Senator Holmberg closed the committee work at 8:29 AM.

Skyler Strand, Committee Clerk

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1233
4/7/2021
Senate Appropriations Committee

Relating to public employees retirement system prescription drug coverage performance audits.

Senator **Holmberg** opened the committee work at 11:12 AM.

Senators present**: Holmberg, Krebsbach, Wanzek, Bekkedahl, Poolman, Erbele, Dever, Oehlke, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- Vote

Senator Oehlke moved Do Not Pass on HB 1233.
Senator Krebsbach second.

Senators			***Senators***	
Senator Holmberg	Y		*Senator Hogue*	N
Senator Krebsbach	Y		*Senator Oehlke*	Y
Senator Wanzek	Y		*Senator Poolman*	Y
Senator Bekkedahl	Y		*Senator Rust*	Y
Senator Davison	Y		*Senator Sorvaag*	Y
Senator Dever	Y		*Senator Heckaman*	Y
Senator Erbele	Y		*Senator Mathern*	Y

Roll Call vote 13-1-0. Motion passed.

Senator Oehlke will carry the bill.

Senator Holmberg closed the committee work at 11:15 AM.

Rose Laning, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1233, as engrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO NOT PASS** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed HB 1233, as amended, was placed on the Fourteenth order on the calendar.