2017 HOUSE INDUSTRY, BUSINESS, AND LABOR

HB 1403

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
1/24/2017
27290

☐ Subcommittee
☐ Conference Committee

Kathleen Davis

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachment 1, 2

Chairman Keiser: Opens the hearing of HB 1403.

Rep Kasper~ District 46 from Fargo:: Good morning, Mr. Chairman and members of the committee. For the record, Rep. Jim Kasper, District 46 in Fargo. We have a simple bill. We've seen this before. Non-controversial and I think everybody's going to love it when we talk about it. This bill deals with, first of all the ND Public Employee's Retirement System health plan, which insures all of the employees of the State of ND, and us, as a matter of fact, and it also deals with one other components of the health plan, and in most cases, all health insurance plans of the same component, that is the prescription drug part of the health insurance plan, and the prescription drug parts of health insurance plans are managed by entities called PBMs, or pharmacy benefit managers. Little bit of history about PBMs, Mr. Chairman. Way back 20-30 years ago, I can't tell you exactly when, the insurance companies in order to record and have a record keeping process of how prescription drugs were applied for by the patient to the pharmacist, had a record keeper to do so, and they were called PBMs. And the need was to be able to show the cost of the health insurance plan. So as an example, we go to the doctor and the doctor gives us a prescription and we'd go to our pharmacist. The doctor will send it to the pharmacist and it's all waiting for us. What happens when that prescription hits at a pharmacist from the doctor? The pharmacist enters it into the system, verifies the health insurance plan that we're covered under, and sends it to the pharmacy benefit manager, the record keeper for drugs. Pharmacy benefit managers are all over the United States. They're a multi-billion business. They have grown dramatically over the years. At the beginning they were simply charging a fee for their service. They would get $4-$5 per service. They would bill the plan, and they would tell the pharmacist, you collect the co-pay and they would say to the pharmacist, we will give you like $10 or $20 or $30 to fill that prescription and everything was fine for a while. As all business models evolve, you being to think in the capitalistic method of how can I make more money for my business model other than this modest $4 prescription fill? And as prices begin to escalate, the PBMs, began to look at ways where they could make more money than simply that prescription pill charge. There's a number of ways that they are able to do so very creatively. One is through

rebates. What is a rebate? A rebate is a portion of the prescription drugs spend that a manufacturer gets paid for the drugs that are purchased for that prescription. As an example, high blood pressure medication. There's 8 or 10 different high blood pressure medications and some of them are old and some of them are new. So when your doctor fills a prescription drug for high blood pressure, you go to the pharmacist. The pharmacist will look at that and if the doctor did not prescribe a generic drug, which has been on the market for a long time but now is opened up with a lower price, the pharmacist would say, I'm going to recommend that we do a generic drug here. And so that would save you money. It would save the plan money. Everything is good. Well the pharmacist benefit manager, when they began to look at rebates, they began to say, "how are we going to drive the prescription drugs spent to these various manufacturers?" So they came up with formularies. And the formulary is a list of drugs that are offered to that particular health insurance plan and each health plan has a formulary and they can be different based upon the size of the health insurance plan and negotiation with the PBM, and the health insurance plan and so on. Well negotiation with the health plan is non-existent but negotiation with the insurance carrier. And so they began to narrow the scope. So they would say out of these 10 high blood pressure medications, we're only going to have 3 on our formulary. And now we're going to contact those 3 manufacturers and we're going to make a deal with them. We're going to say, we are going to drive prescription drugs for high blood pressure, to just these 3 companies, and we're going to exclude these other 7. In return, at year end, we're going to do an audit of our prescription drug spend, and we're going to send you the audit and we're going to ask you to give us a rebate because we're sending more business your way. And that happens. Now it happened way back when. The problem is, what happens to the rebate? Now remember who's paying the bill. The insurance company in the case of our bill here, ND PERS, the employer pays the bill. But in our case, it's not the employer, it's the state of ND and the taxpayer dollars that is paying the bill. So as wise stewards of the public money, it's been my contention for years, that it is our fiduciary responsibility to find out what's happening behind the scenes on these rebates. Because in most cases, the pharmacy benefit manager keeps the rebate. In some cases, they'll share it with the insurance company, but in too many cases, the employer is left out of the formula. Now the larger companies in the country, where they're dealing with hundreds of thousands or many thousands of employees, who have their own attorneys, they know how to make the deal the right way so they'll put in their contracts with the insurance carrier, that they will audit the PBMs, they will find out exactly what is going on behind the scenes and in many cases, in their contract, they will have a provision that says of all the rebates that are collected by the PBM, the employer is going to get X%, the PBM can keep part of it, the insurance can keep part of it and so on. And that the larger companies do that. But you know what, in ND's case, we don't do that. To my knowledge we have never audited our PBM, so we don't know what's going on behind the scenes with the rebates. Now, we're dealing with premiums in the neighborhood of $2-$3 million that we're paying with taxpayer's funds. Prescription drugs generally account for 20-25% of the health care costs and it's increasing dramatically in particular with these new specialty drugs that are coming out and we don't know. So this bill, one other way, is spread pricing. Which I will get into that and then what the bill does. Spread pricing is a method that some PBMs utilize and have gone, been taken to court, and have lost 100s of millions of dollars in court cases once the onion has been peeled back to see what's going on in spread pricing. So here's what happens on the spread price. We go back to, we go to the pharmacist, with our prescription, and we get our high blood pressure medication, and let's say the PBM paid the pharmacist for the cost of the drug, let's just say $10. We pay the Called the committee to order on-pay of $5, but

that's a total of $15, ah $10 that is paid out by the PBM, when the record keeping part of it, the PBM charges the health insurance company $20. That's a spread. They paid out $10, they charged the health plan, the employer $20, and they keep the spread for their profit. That happens many times and it's happening today all over the country. I think those are somewhat insidious but there again, if the employer does not have the right or the knowledge to audit the plan, they never know what's going on. So, Mr. Chairman, and members of the committee, this bill is very simple. It says that the PERS board, when they enter into a contract with our health insurance company, the contract with the health insurance company, whether they're fully insured or whether they're self-funded, the PERS board has the right to hire an independent auditor and to audit the prescription drug spend and record keeping behind the scenes. And the audit, there's auditors all over the country, that specialize in auditing PBMs. In many cases, the auditors won't even charge a fee to the state in this case. They're contract might say, our fee will be 10% as an example of the dollars, that we save the plan. So if we don't save you any money by find out what's going on with the PBMs, you don't owe us anything. In some cases, they'll negotiate a fee they'll negotiate a fee and that's a matter for the PERS board in this case to determine. So this says the PERS board may audit the PBM if the PERS board desires, if they enter, and they shall enter into the contract with the insurance company, that they have that right. It also says that the PERS board would be able to hire an independent auditor and it says that the information, because this is confidential information, stays confidential. So it will not be made public, names of people that are having prescription drugs it's totally confidential, and the other parts of the audit are also confidential because the PBMs hide behind their contractual relationships, and they say these are very very confidential matters that we are negotiating, and we do not wish for this information to be divulged. One other point Mr. Chairman and committee members, that I find egregious about PBMs is the way they treat local pharmacists whether its ND, whether it's MN, whether it's TX, it doesn't matter, the concept is the same. The PBMs because we have never been able to see the contractual language, we don't know what their contract is with the pharmacist, because they also enter in to individual contacts with all the pharmacists that they do business with. And they put right in the writing of that contract, that this is also proprietary information, pharmacists are not allowed to talk to other pharmacists about their contract with the PBM because its proprietary information. But what we find is that PBMs are doing, is treating our local pharmacists, in many cases very poorly. In some cases they're reimbursing them less than the cost of the drug, and so, I don't know about your business, but I know if my businesses we're not able to, if my costs were $100 and I was reimbursed $50 I wouldn't be in business very long. And the local pharmacists have been trying for years to be treated more fairly and better. It's very very difficult to do when you're holding all the cards. And so a, this will help open up what is happening behind the scenes with our state health plan in the area of pharmacy benefit drugs. And Mr. Chairman and members of the committee, I submit to you, that it is our fiduciary responsibility as legislators to investigate and allow the PERS board to determine what is happening with our PBMs. Because we pay the bill, the citizens of ND pay the bill. And it's our responsibility to finally find out what's happening and put some transparency, although it's confidential, with the board and the PBMs. So Mr. Chairman, with that explanation, I'd be happy to answer any questions.

13:10

Rep Ruby: You mentioned the spread, when there is one you said it's, what was the term you used? egregious, ok. Who is, if there is one, and when there is one, who is to determine what the appropriate percentage of profit is?

Rep Kasper: Mr. Chairman, Rep. Ruby, the spread has nothing to do with profit. The pharmacy benefit manager is paid on a fee for service for their service to the plan.

Rep Ruby: You said that it goes directly to their profits.

Rep Kasper: That's correct. The point is disclosure. The spread pricing and the rebates in almost all cases, are not disclosed to the employer, who is paying the bill. I believe we have to have transparency to find out if there is price spreading in our ND PERs plan? There may not be. We've never audited so we don't know. I say we need to find out. Citizens of ND are paying the bill.

Rep C Johnson: Is there a possibility that we could go with a different pharmacy benefits manager? Is there a possibility that PERS could bypass them all together?

Rep Kasper: When you have a fully insured health insured plan, which we do right now, when PERS negotiates with the health insurer, the health insurer contracts with the PBM, and that's part of the health insurance contract with the PBM, so that's never disclosed. That's one of the argument you'll get, fully insured plan, there is no risk to the state because there's a premium. What drives premiums are costs. I don't care whether it's fully insured or self-funded, we need to know. When it's a self-funded, then the PERS board would be able to negotiate separately with the insurance company for the doctors, the clinics, those types of things, and they could negotiate separately with a PBM and have a separate contract there. Most self-funded plans that have large employee bases, they do just exactly that. They're self-funded because they're larger and they negotiate two separate contacts with the health insurance plan and the PBM. In this case, the PERS board does not do that. This would allow them to do that.

Rep Beadle: You mentioned the impact on the local pharmacists themselves, and the costs associated. Does this address that issue?

Rep Kasper: No, this does not.

Rep Beadle: Are there anyone that can do PBM's locally?

Rep Kasper: Not in ND that I'm aware of. There are some bills in the Senate that are addressing some of the local pharmacy issues. If they pass through the Senate I would assume they'd be in our committee.

Rep Beadle: Do we have anyone locally that could do a PMB audits, or would we have to contract elsewhere.

Rep Kasper: I'm not aware of any local entities. There are national entities that specialize. It's highly technical, you need the right software, big investments, you need to know what you're looking for and you need to understand drugs. None in ND that I'm aware of.

Rep. Beadle: When we had the PERs discussion last session, one thing we heard from Sanford & Blues, ND Public Employees plan is not that great of a plan for them because it tends to be a loss leader because we're a very expensive plan due to ages, benefits, etc, a very expensive plan to provide. Would there be a scenario, where we take the profit from one area and they charge elsewhere?

Rep Kasper: The vast amount of the profits is kept by the PBM and do not affect the plan. In this case, it would be found out through the audit process.

Chairman Keiser: ND is the only state that is fully insured. Legislative leadership and the governor like that because there is predictability in being fully insured.

Chairman Keiser: Page 1, line 20, "it will be implemented", could we also add "or modify"?

Rep Kasper: Anything we can do to improve the language; I have no objections.

Pat Ward~Representing Express Scripts a PBM that does business in ND. (Attachment 1). If PBM's are a business and they try to keep pharmacy prices down. PBM's are a watchdog on pharmacies. This is the 1st time since 2005, but I think we can support this bill but it's a state plan and needs transparency.

Rep Kasper: The question I have on your amendment. When your PBM is looked at, I want to be sure that your language doesn't prohibit the ability for the PBM auditor to make sure there is no spread pricing, rebates, etc.

Ward: I believe that a state has the right to the transparency of a health plan. This will allow the state to look into the pharmacy services agreement between the health plan, and the pharmacy benefit manager, which is a separate contract. (30:10) For the state after the fact to pass a law to say they can look inside an existing contract, for example one between Sanford and the PBM, we would have an issue with that. Can we do this differently? Yes. We've already passed laws in past session that allows PERS to unbundle it. The PERS board could hire its own pharmacy benefit manager. (30:50)

Rep Kasper: What I think you said is no. Your agreement would allow the agreement to be audited but not the individual transactions to be audited.

Ward: To be sure, I would have to get back to you. Sanford could have a contract. I don't think the state can pass a law to say it can look inside an existing contract.

Rep Kasper: The PERS board has acted to renew the contract with Sanford for the next 2 years. So therefore a new contract July 1. I would be willing to concede the current contract but the new contract coming up, I will not go along with this amendment unless there's clarification from you and Express Scripts.

Ward: I will try to verify that. As far as going forward, we would not have any problem with that.

35:00

Chairman Keiser: We have an inherent conflict of interest. There is a difference between 2 certified formularies in the state, one is owned by Sanford Health. How do we look at those contracts to make sure they're offering the same discount rates to the two providers, one in network? Will our audits be able to look at that kind of information?

Ward: I believe they will if the PERs board chooses to put that option when they negotiate contracts with Sanford, or if they negotiate directly with a PMB. I'm sure it will.

Mike Schwab~Executive Vice President of ND Pharmacists Association: Attachment 2 in support of HB 1403.

Rep Lefor: You refer to lines 11-14, if they are able to expose the details, are they disclosing them to the PERs board only or does the State of ND, the one that actually pays the bill have access to that information?

Schwab: My understanding is that it allows the PBM's to be audited. On Page 2 Lines 13-16, that information will be confidential with the ND PERs board, or any other experts.

Chairman Keiser: The contract issued was a modified contract. Technically, we can't appropriate any money. If we enter a new contract, does a renewal qualify as a new contract and bind us?

Schwab: My guess, is if you're looking at to renew a contract, from a business perspective contract, when you renew a contract, you are technically, in my opinion, opening a contract for discussion. Maybe that opportunity would be there.

Rep Kasper: My intent is to audit the next contract, July 1, 2017, and we can put in this bill statutory language that the PERs board must sign and enter into a new contract for the renewal so that they can clarify that.

Chairman Keiser: Further testimony? Opposition, neutral? The hearing closed on HB1403. Rep. Kasper is the carrier.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
1/30/2017
27608

☐ Subcommittee
☐ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachment 1

Chairman Keiser: Reopens the hearing on HB 1403.

Rep Kasper: I had an amendment drafted that would exempt HB 1403 go before the Employee's Benefits Committee. Attachment 1.

Chairman Keiser: There is a standing committee, Employee's Benefits & if there is any bill affect employees, is to go to that committee. However, there is a legal question, that when the legislature is in session, that committee doesn't need to see any of these bills, especially if we put that amendment on it.

This committee did take this bill up, against the objection against the leadership because we have the bill in this committee, at this time. they don't have the authority to take this bill from us at this time. Chairman Keiser, Rep Kasper, & Rep Carlson really feel strongly about this & it might be an understatement. We do think it's our propagative as a full legislative body to address this issue & not have them stop it or derail it because it's such an important issue to our state.

Rep Kasper: Moves for amendment.

Rep Bosch: Second.

Chairman Keiser: Further discussion?

Voice vote – Motion carried.

Rep Kasper: You have heard my testimony about why we need this bill. I was going ask Pat Ward because he represents the PBM's, if the number of lawsuits over the last 15-20 years that have been filed against PBM's, about fraud & misuse of their fiduciary responsibility. The PBM's like to say that they don't have fiduciary responsibility, but in some cases it's been ruled that they do. There has been million dollars of fines levied & rewards

made by the courts against the PBM's. They are not disclosing what they are doing behind the scenes. For PERS to not audit our state health insurance plan on the PBM side, there is a lack of fiduciary responsibility by the PERS board members.

In the 2015 session, fought & tooth & nail to try to get some of these issues on the PERS's bill but in the end we did not get it on. To me, we pay the bills, the citizen's tax payer funded, we have the obligation to find out what is going on.

Rep Ruby: I will as the committee to further amend, page 1, line 20, add modified after implemented.

Rep Ruby: Moves the amendment & further amend.

Rep Dobervich: Second.

Chairman Keiser: Further discussion?

Voice vote – Motion Carried.

Rep Ruby: I think Pat Ward had an amendment as well, could we have some discussion on that?

Rep Kasper: That amendment kills the bill, it's tricky, they can audit the contract but they can't audit what is going on behind the scenes.

Rep Ruby: Audit the contract, right, isn't that what you wanted to do?

Rep Kasper: No. You have to follow the money & the only way you can follow the money is audit the PBM.

Chairman Keiser: We have HB 1403 as amended & further amended.

Rep Kasper: Moves a Do Pass as Amended.

Rep Dobervich: Second.

Chairman Keiser: PBM's from the offset, were a great concept in terms managing organizations manages things. They have become huge businesses. I believe in the top 10 highest volume businesses in the US, 2 of them are PBM's.

Rep Kasper: When the audit id done, it's totally confidential about each individual. You are keeping them honest.

Rep C Johnson: When we do the audit, the PBM, that information goes to the PERS board.

Chairman Keiser: Correct.

Rep Kasper: The result will go to the PERS board, only the data will go to them, not the personal information.

Rep Bosch: So Pat Ward amendment is not on the table.

Chairman Keiser: It is not, correct. Further discussion?

Roll call was taken on HB 1403 for a Do Pass as Amended with 13 yes, 0 no, 1 absent & Rep Kasper will be the carrier.

17.0720.01001
Title.

Prepared by the Legislative Council staff for
Representative Kasper
January 25, 2017

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1403

Page 1, line 2, after "transparency" insert "; and to provide an exemption"

Page 2, after line 16, insert:

"**SECTION 2. EXEMPTION.** This Act is exempt from the jurisdiction of the employee benefits programs committee under section 54-35-02.4."

Renumber accordingly

1/31/17 DO

17.0720.01002
Title.02000

Adopted by the Industry, Business and Labor Committee

January 31, 2017

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1403

Page 1, line 2, after "transparency" insert "; and to provide an exemption"

Page 1, line 20, after "implemented" insert "or modified"

Page 2, after line 16, insert:

"**SECTION 2. EXEMPTION.** This Act is exempt from the jurisdiction of the employee benefits programs committee under section 54-35-02.4."

Renumber accordingly

Date: Jan. 30, 2017

Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1403

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description: 17.0720.01001

Recommendation

☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐ _____

Motion Made By Rep. Kasper **Seconded By** Rep. Bosch

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Rep Laning		
Vice Chairman Sukut			Rep Lefor		
Rep Beadle			Rep Louser		
Rep R Becker			Rep O'Brien		
Rep Bosch	Voice Vote.		Rep Ruby		
Rep C Johnson			Rep Boschee		
Rep Kasper			Rep Dobervich		

Total (Yes) _____ No _____

Absent _____

Floor Assignment **Voice vote ~ Motion carried**

Date: Jan. 30, 2017

Roll Call Vote #: 2

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1403

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description: amend pg 1, line 20 add modified after implemented.

Recommendation

☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐ _____

Motion Made By Rep. Ruby **Seconded By** Rep. Dobervich

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Rep Laning		
Vice Chairman Sukut			Rep Lefor		
Rep Beadle			Rep Louser		
Rep R Becker			Rep O'Brien		
Rep Bosch	Voice Vote		Rep Ruby		
Rep C Johnson			Rep Boschee		
Rep Kasper			Rep Dobervich		

Total (Yes) _____ No _____

Absent _____

Floor Assignment **Voice vote ~ Motion carried**

Date: Jan 30, 2017

Roll Call Vote #: 3

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1403

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description:

Recommendation

☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐

Motion Made By Rep Kasper **Seconded By** Rep Dobervich

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	X		Rep Laning	X	
Vice Chairman Sukut	X		Rep Lefor	X	
Rep Beadle	Ab		Rep Louser	X	
Rep R Becker	X		Rep O'Brien	X	
Rep Bosch	X		Rep Ruby	X	
Rep C Johnson	X		Rep Boschee	X	
Rep Kasper	X		Rep Dobervich	X	

Total (Yes) 13 No 0

Absent 1

Floor Assignment Rep Kasper

REPORT OF STANDING COMMITTEE

HB 1403: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1403 was placed on the Sixth order on the calendar.

Page 1, line 2, after "transparency" insert "; and to provide an exemption"

Page 1, line 20, after "implemented" insert "or modified"

Page 2, after line 16, insert:

"**SECTION 2. EXEMPTION.** This Act is exempt from the jurisdiction of the employee benefits programs committee under section 54-35-02.4."

Renumber accordingly

2017 SENATE HUMAN SERVICES

HB 1403

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1403
3/7/2017
Job Number 28794

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Bonn

Explanation or reason for introduction of bill/resolution:

A bill relating to public employee health benefits transparency; and to provide an exemption.

Minutes: 3 Attachments

Chair J. Lee: Brought the hearing to order, all members were present.

Representative Jim Kasper District 46 (1:20-2:20) introduced the bill.

Senator Piepkorn: What is a self-funded health care plan?

Rep. Kasper: A fully insured health plan is what we have with the state of North Dakota, whereby the insurance company provides a quote for the benefits and a premium for the benefits and all of the risk with the fully insured plan is borne by the insurance company. A self-funded arrangement still has the insurance benefit, but you now have a plan where you hire a third party administrator the plan is designed so that a portion of the cost is paid for by the dollars generated by the plans, and a portion of the claims above a certain level, called a stop loss level are paid for by the insurance company. There is a sharing of the risk.

Chair J. Lee: Please explain why one would purchase one rather than the other.

Rep. Kasper: Generally, if you design your health insurance plan properly and are large enough numbers that are covered by the plan, in the case of the state of North Dakota, we have approximately 68,000 covered lives in that plan. There is a benefit in most years if you are self-funded, because if you have good claims years; where the expected claims were x and claims were y, which is lower than x, the plan can keep the dollars in reserve. Under a fully insured plan, if you have a year where the claims were lower than expected, the insurance company keeps the difference, because they have 100% of the risk. Under a self-funded plan, you have the opportunity to share in the gains of the plan if you properly fund the plan.

Chair J. Lee: It would be an employer that would be doing a self-funded plan.

Rep. Kasper: The employer sponsors the plan, that's correct. In most cases, if an employer has 100 employees or more, that employer will obtain a quote for fully insured plan and a self-funded plan and compare the costs. Any employer with 500 or greater employees all are self-funded. North Dakota used to be self-funded; it ran into trouble because they didn't properly fund the risk. If you properly fund a self-funded plan, the employer can't lose money.

(7:00-18:10) HB 1403 deals with Pharmacy Benefit Managers (PBMs), PBMs are an integral part of all health insurance plans. The medical side is covered by medical side of plan but pharmacy part of the health plans is handled by PBMs; they became prevalent 20-25 years ago. When we get a prescription filled, the pharmacy bills the health insurance plan. PBMs have become secretive, not disclosing activity to employers. This bill is to say we as a state of North Dakota have the opportunity and responsibility to know what's going on with the pharmacy behind the scenes, it authorizes PERS to commission a report from an audit firm, the records are confidential. There is an article, "You're Overpaying for Drugs and Your Pharmacy Can't Tell You," written by Jared Hopkins, on February 24, 2017 that has some very good information. He describes what happens and why the pharmacists are gagged by the contract that they sign with many PBMs about disclosing information that the pharmacists think is necessary for the people to know but the contract that they signed prohibits them from providing this type of information. This bill will allow us to look behind the PBM that the state hires and find out what's going on. There are two main areas, one is the area of rebates. When a PBM is hired they negotiate a formulary. They will then negotiate with the drug manufacturers for a rebate anywhere from 5%-30%, this is a hidden negotiation. If you're a fully insured health plan, you don't see past the barrier. The PBM keeps the rebate. We want the audit to check the rebates, this is employer paid money. It is our responsibility to obtain the facts about how much money is being earned by rebates, and what is happening to the rebates. Secondly, spread pricing is when the pharmacy receives one amount to fill a prescription, but the PBM bills the plan a higher amount. It's a way for PBM to increase profits.

Senator Heckaman: It says on the back page line 5, "The board may conduct annual audits," was a fiscal note needed?

Rep. Kasper: Because this isn't requiring, there is no fiscal note. In most cases an audit company would make a hold harmless offer. They often find lots of interesting things; their fee might be 10% of savings we bring to the plan. I don't think we need a fiscal note at this time.

Senator Heckaman: If something is found out, what teeth are in the bill to do something about it; what could PERS do? Do we have the ability to go to a big PBM and ask for money back?

Rep. Kasper: When the audit discloses whatever it finds, it would require the PBM to return money to the fund. If the committee wants to put a more toothful amendment in, I have no objection.

Chair J. Lee: There's nothing more convoluted than prescription drug pricing.

Senator Clemens: There's no way to bypass PBMs? This is the nature of it?

Rep. Kasper: That's correct. It's a key element, there's a lot of good things that PBMS do, they're an integral part of a health plan. It would be almost impossible to duplicate what they're doing. There are PBMs who have a fully transparent model, won't do spreads or rebates.

Senator Clemens: So when North Dakota negotiates insurance, couldn't we have that written in? That that stuff is transparent?

Rep. Kasper: That's what this bill is doing, Mr. Collins tells me that there is some section of the code where they could do an audit, but I've never seen one, so this is bringing the subject to the floor.

Senator Kreun: I am assuming that we've been doing internal audits, and not external, and this is an option we're looking for.

Rep. Kasper: This would be an external audit by a specialist.

Senator Kreun: Have we done this before?

Rep. Kasper: not to my knowledge.

Chair J. Lee: DHS does get rebates on drugs, the law prevented them from doing it until a few years ago when we fixed it. We are now getting several million dollars in rebates.

Senator Piepkorn: Who other than ND PERS might benefit?

Rep. Kasper: I believe almost any employer with a health insurance plan would benefit from an audit like this if they have never done one.

Senator Piepkorn: It seems anti-traditional Republican philosophy. The ultimate free enterprise. Here we seem to be sticking up for the little guy.

Rep. Kasper: Ignorance is bliss, so bringing these concerns to light of day, and having PERS implement audit might open up some eyes

Senator Heckaman: Who else can benefit, this addressed to the PERS plan?

Rep. Kasper: This is just the PERS.

Patrick Ward, Express Scripts (27:00-33:25): We have the North Dakota contract, through Sanford, we don't oppose this bill, as this is something that PERs could do already. We have all kinds of plans. We have fully transparent plans, some companies want to know what the rebates are, what the spread pricing is, and get that money refunded to them, but then they're also taking the risk. Some companies prefer to let PBM take the risk with a fully insured plan, which is what you have right now. Based on some testimony, you guys came out really well, Sanford took a hit. I do have a single copy of a PowerPoint **(Please see attachment #2)** it's fairly detailed, explains what PBMs do. Gave a car salesman example. Rep. Kasper says pharmacists can't disclose certain aspects of his contract, they become part of a pharmacy

network. There are nondisclosure clauses and antitrust issues to help keep them competitive. PBMs negotiate and coordinate the prescription benefit for employer. PBMs have the power to go toe to toe with drug companies, the drugs are protected, they're patented; until they become generic, there's no competition for price. We try to encourage the use of generic drugs. We're neutral on this bill, we believe the state has the right to do this. Every time PBMs are studied, they are found to save money in the long run, they keep the drug spend increase percentage-wise down. The increase for health care cost increases more than drug cost where PBMs are involved. What we don't want to see is interference with our freedom of contracts or our existing contracts. It's unconstitutional and invades freedom to negotiate contracts.

Senator Piepkorn: With the transparency there comes certain amount of risk for PERS?

Mr. Ward: Yes, there does, Mr. Collins can answer better than I.

Senator Piepkorn: Because if there wasn't there would be no big deal.

Mr. Ward: They have the option now, to negotiate that type of contract moving forward.

V-Chair Larsen: I like the car dealership analogy. There's an open market, and the dealership may be getting rebates too.

Sparb Collins, Executive Director, ND PERS (35:30-40:50) testified neutral please see attachment #1. Presented amendments.

Senator Heckaman: Were some of these recommendations addressed to the House?

Mr. Collins: No, they weren't.

Senator Heckaman: Are any of these of real substance?

Mr. Collins: There are some that are substantive in terms of clarifying. What Deloitte is trying to make sure the clarification of the intent of some of the provisions.

Senator Heckaman: I'd like to hear what they are.

Mr. Collins: (42:15-46:00) please see attachment #1, page 2.

Senator Anderson: I appreciated the fact that you cleared up that your contract's with the insurance company, it doesn't quite compare to the auto dealer situation we talked about, you don't really have a contract with the PBM, that just saying you can reach out to audit them even though your contract is with the insurance company, and the insurance company might change the PBM next year, you have no control over that.

Mr. Collins: Under this type of one, if we had a self-insured plan, then we would have specific contracts with a PBM, disease management companies would probably have numerous contracts right now. Fully insured, the carrier does that contracting, they get the advantage of doing that on behalf of all of their business.

Senator Piepkorn: These recommendations come from Deloitte, you're comfortable with them?

Mr. Collins: I should have said clarifications. The next one (47:38-49:50) please see attachment 1 page 2a.

Senator Anderson: What is the implication of page 2 lines 17-18, where we're exempting this from the jurisdiction of the employee benefits program?

Mr. Collins: That's something we didn't look at, that's policy, but I can tell you it went to the Employee Benefits Committee, they did look at the comments prepared by Deloitte, if I remember correctly they gave it no recommendation.

Senator Anderson: The practical matter of the language that exempts it from their jurisdiction what does that say?

Mr. Collins: I'm not sure.

Senator Anderson: That committee makes recommendations to you, correct?

Mr. Collins: If it has an effect on PERS it goes to that committee for a review. They forward to you a finding: favorable, no recommendation, not favorable recommendation.

Senator Anderson: As a practical matter it has no effect, is that what you're saying?
Mr. Collins: I think so, but I'm not an attorney.

Chair J. Lee: I don't see any harm in having employee benefits involved.

Mr. Collins: It's gone through the process. Those would be our observations on the bill. We would be willing to work with Rep. Kasper to prepare some amendments.

Mr. Ward: To clarify Senator Heckaman, the exemption on section 2 is what was added in the House as it was engrossed. Nothing else was changed, I don't know why that happened, I was at the hearing, that wasn't discussed.
Attachment #3 was provided after the hearing for the committee's reference.

Chair J. Lee: closed the hearing

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1403
3/21/2017
Job Number 29500

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to public employee health benefits transparency; and to provide an exemption

Minutes: 1 Attachment

Chair J. Lee: Brought the meeting to order, all members were present.

Sparb Collins, Executive Director, North Dakota PERS (0:50-5:00) HB 1403 sets requirements relating to how we work with Pharmacy Benefits Management (PMBs), sets some audit requirements relating to that relationship. The Board has no objections to the idea of being more active, our concern is at a much broader level, as presently written, it is a mandatory criteria that when we go out to bid, it's a mandatory that we can go in and audit. The Board suggested is to set that as a preference criteria in the bid. Mandatory requirements would be added as a minimum requirement; this might exclude things from consideration. Preference criteria, the bid gets reviewed. All things being equal, the audit bid gets preference. Example: prescription drugs benefits are important, but they are 17% of expenditure, the other 80% relate to hospitals, outpatient etc. A proposal comes in and audits are a minimum requirement, that proposal may have things that makes the 80% cheaper, we will have to throw it out. If it's a preference criteria, we can review it. There may be situations where there are offers made that are more advantageous.

Chair J. Lee: One of the things I struggle with is in section 2, which says that this act is exempt from the Employee Benefits Committee, until that passes, it's not exempt. I would like to see this go to Employee Benefits, I was told they looked at in January.

Mr. Collins: They did, it was the non-engrossed version, it was a neutral recommendation. We have no objections to doing audits.

Chair J. Lee: Would you also have no objection to having the bill die?

Mr. Collins: I don't know.

Senator Piepkorn: Without an audit, how do you know all things are equal?

Mr. Collins: In a proposal, you aren't doing it based on the audit, you're doing it based on the proposal. The audit is an after the fact, at that point going back and making sure what we were told in the proposal and what we negotiated is being adhered to. When I say all things equal, it's based upon that proposal.

Senator Piepkorn: What would you say is the primary advantage to PERS for changing the language and making it a preference?

Mr. Collins: It gives the board ability to weigh all the factors and make the best decision. When it's mandatory, it may get thrown out, may not look at the more favorable arrangements on the medical side, because it doesn't meet something relating to the prescription drug side. You want to be able to look at the entirety of the proposal and make a decision, then if there's a preference you view it all, if all things come up equal you apply these preferences. You do that after the review. The mandatory ones are applied up front.

Senator Piepkorn: Would some of the PBMs just drop out?

Mr. Collins: They could, companies look at our requirements, and why go through the time and effort if they don't think they're going to get considered. It takes a lot of time and effort to prepare a proposal.

Chair J. Lee: PERS does not hire the PBM, the insurance carrier that gets the contract does. We are leapfrogging over the insurance company, telling them we have the right to tell them which PBM to hire.

Mr. Collins: Under a fully insured plan, since that carrier is taking all the risk, they don't want us hiring people because then we're taking on risk for them.

Chair J. Lee: We are tying their hands in areas where they may have a need to do something different.

Senator Heckaman: On the 1st page, this has nothing to do with audits? This has to do with the contract itself. Because audits are on the back page.

Mr. Collins: This says, the contract with the board must include the following terms. So those are the terms.

Senator Heckaman: To me, b is really cumbersome.

Mr. Collins: We have a smaller amendment for that where it goes to monthly.

Senator Heckaman: You have the ability to audit them?

Mr. Collins: Yes, however this provides specific audit authority. It also sets it up, if it's a preference criteria, everything being equal this is our preference we want companies that are going to allow us to do this.

Chair J. Lee: You could put that as part of your contract with whatever insurance contract you're dealing with. You could as a board establish that criteria if you wished to do that. It doesn't need statutory support.

Mr. Collins: You have established for us a series of review criteria, I think there are five, this makes it six.

V-Chair Larsen: I don't believe this is a new issue, and you have the ability to do it, is there a reason why there hasn't been movement forward by the board to implement it so this is a non-issue. If I remember right, there's been heartburn for a while.

Mr. Collins: We did an audit at BCBS, this provides more direction, you get into these audits, it's complicated. What we do in the fully insured contract is we say when it comes to pharmacy, there are rebates that they get that come back to us, we'll audit to make sure we are getting back our rebates. There are other things in there, like spread pricing, we'd like to know if we should audit that. End up with questions about scope of the audit.

V-Chair Larsen gave a car dealership example.

Mr. Collins: Let's expand, what if the deal you made was this price, less any rebates on the vehicle. The price is $25,995 less the rebate, you might want to know what the rebate is, verify the deal.

Senator Anderson: It seems section 1 is intended to lay out criteria that you need to know, where it starts in d, you may audit. If you don't have the information on the 1st page, it's very difficult to audit, because you don't have the criteria that you've asked for to audit against. I disagree with Senator Larsen, this is a situation where PERS is contracting with an insurance company and expecting certain things, it's not like car dealership, this is where a company contracts with the dealer, and says we're going to get all the rebates you get from the manufacturer, and the dealer says ok. Later, the only way to figure out if you got it is to audit; that's the difference between the scenarios.

Chair J. Lee: Closed the meeting.
Attachment #1 provided for committee's reference.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1403
3/22/2017
Job Number 29547

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to public employee health benefits transparency; and to provide an exemption.

Minutes: 2 attachments

Chair J. Lee: Brought the meeting to order, all members were present.

Sparb Collins, Executive Director, ND PERS (1:15-6:00) please see attachments #1, 2.

Senator Piepkorn: The auditor still goes in, who has access to the information?

Mr. Collins: The board and I could have access to the information, but we would have access in a confidential nature. A report today could be argued as public record, this allows us to look and retain confidentiality.

Senator Piepkorn: If the auditor didn't report to you, where would the circumstance come to need to do anything with it?

Chair J. Lee: Public can get it on open records, no business know what the proprietary business interests are.

Mr. Collins: Every time we run a bid process, we'll get a series of bids in, once the successful proposal is chosen, I get a letter from the competitors asking for a copy of the proposal. It's a learning opportunity for them.

Chair J. Lee: When we got the new health care coverage, there were questions about coverage under the new system, I forwarded them to you, because you knew how to deal with this. Neither one of them can know what the other's program was. It's not a thin line, the public doesn't understand how that works.

Mr. Collins: This information is competitive advantage, we're getting to the heart of what they pay, they guard that information very closely. If Sanford was able to access BCBS, they would want the same as BCBS, negotiation gets to be more of a disadvantage of everybody

involved. This says we'd be able to maintain this as confidential. The last section is in there; it authorizes the board to pick the auditor.

Chair J. Lee: Rep. Kasper did say he will go along with these amendments; I don't think we're going to get a big fight about this part.

Mr. Collins: I know he'd prefer to have more stringent provisions regarding the audit.

Chair J. Lee: Since there's such an excellent renewal that's been negotiated, PERS will recognize the benefits of the savings, its seems good job of working out an appropriate contract that is good for the state and people's health services. If we were terribly unhappy, I'd have a different view, but I think things are being handled very well.

Mr. Collins: We don't get to negotiate the contact with PBM.

Chair J. Lee: No, but that's the point, we are leapfrogging over Sanford Health to say we want to see what the PBM you hired is doing. I'm not entirely comfortable with doing that. If you negotiate that in the contract, that's between those parties, but to say, no, we get to do this in spite of the contract, I have a level of discomfort with that.

(13:00-15:15) The committee discussed transparency and news reporting.

Senator Anderson: I think the purpose of the bill was to make sure the board of PERS gets to look at that PBM contract and see if the PBM is fulfilling their expectations as far as what they've agreed to. It's much too complicated for public to sort though, whether it stays confidential with PERS, the more they get to look at, the better off they are, as far as being able to assure they're getting what they paid for. As far as the public seeing all that, it's a barrier to the PERS board seeing more. I think it's important that we have those protections in there so that the board can look at everything.

Chair J. Lee closed the meeting.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1403
3/27/2017
Job Number 29700

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to public employee health benefits transparency; and to provide an exemption.

Minutes: 1 attachment

Chair J. Lee: Brought the meeting to order. All members were present.

Senator Piepkorn: I learned Rep. Kasper has been in Vegas, his wife is in the hospital.

Chair J. Lee: We had waited until Employee Benefits committee met, apparently it was a really ugly meeting. They split it, Kasper's portion received an unfavorable review; Sparb Collins' portion got a favorable review. What we will do is look at Sparb Collins' amendments, from March 22nd. We talked about how they can put it in their request for proposals that there will be an opportunity for the PERS Board to request an audit, the PERS Health Program Board contracts with the insurance provider, they are the ones who contract with the PRMs for overseeing the prescription drugs prices. In my view are looking at being asked to leapfrog over the board that runs the program. (3:00-4:40 Break to get copies of amendment. **Please see attachment #1**) I had concerns about stepping over the board that runs the project and over the insurance company with whom the contract has been signed for the Legislature to go in and micromanage an audit.

V-Chair Larsen: I can remember, I had this great idea in the summer, we got notification that if you have anything that wants to change: the PERS Board, the retirement system, you have to first go through the benefits group. They have to look at it first. That's what's troubling with this bill; if they wanted to have an audit, that idea should have went through in April so they could review it. To bypass it once is problematic, then to totally put an amendment in it to continually always bypass it; it's too big to not run it through that board first. I can't support that.

Chair J. Lee: That's a bipartisan board.

Senator Anderson: I don't think provision was in the original bill; that was added in the House. The one that came to us, Rep. Kapser's idea.

Senator Kreun: How the oversight is from our elected bodies, who has access to the information?

Chair J. Lee: You mean the PERS one or the other legislative body reviews?

Senator Kreun: PERS. I don't think we should bypass them, I don't think we have enough time, it's not our area of expertise, how does that information transfer back to us?

Chair J. Lee: I assume once it's done, it's public information. Spoke about the function of the PERS board.

Senator Kreun: It's got to be public information at some point we as a legislature could take that report and go over it, why would we need a separate scenario to do that?

Chair J. Lee: The PERS board has responsibility to run the plan, they would be reviewing the audit and if there were problems, they would take care of it. Spoke about specialty drugs.

V-Chair Larsen: We do get reports from the interim committee when we come back in December. If it does go through the right channels, there's a flag that's raised, it's not a blind sighted deal. Where this would be.

Chair J. Lee: Sometimes you shouldn't fix what isn't broken.

Senator Heckaman: Looking at Sparb Collins' amendments, where it says page 2, line 16, insert, there was that section 2 exemption would still remain, I don't see that that was taken out, that's a concern for me.

Senator Anderson: I'm not in favor of that particular section, when I asked Sparb what consequences it had, he shrugged, I don't see a downside if we just take it out. My goal in this bill is to make sure that the PERS Board can audit the PBM. If Sparb thinks his amendments accomplish that for him, that's all we can accomplish by this bill. I know Kapser doesn't like the language 'a preference', he wants a mandate, Sparb thinks it will accomplish what they want.

Chair J. Lee: The pharmacists thought this would be fair?

Senator Anderson: Mike Schwab would like the same language that says you have to have the bid that way. However, it restricts the PERS Board's options trying to get the best deal. I think we should go with this amendment.

Senator Piepkorn: I understand your statement in favor of the PERS Board audit, that's the crux of the discussion, whether it's a may or shall.

Senator Anderson: No, it always says they may audit, whether they shall make it a requirement of the bid, or if it's a preference. That's the difference when they go to sign contact, preference or demand.

Chair J. Lee: Sparb Collins said if there are 2 bids that are otherwise equal they could choose that contract, that's what the preference language is about, take a look at the original bill. Looks like a lot of the language is still the same, it seems the original is everything except they added the provision about avoiding Employee Benefits.

Ian Arendt, Intern: The only other difference is on page 1, line 21, they added "or modified…"

Chair J. Lee: (17:30-20:00) walked through the bill and proposed amendments in comparison.

V-Chair Larsen: That was the discussion, maybe when they do the audit, the PBM part might be more expensive, but the co-pays are cheaper, use that as a balanced product, being stuck to this, you've got to take the cheapest drug policy, and not the best plan.

Senator Piepkorn: There's nothing in this bill that says what you just said.

Chair J. Lee: But that's what's inserted on page 1, line 20.

V-Chair Larsen: Before this bill they were just doing an audit on the pills and the formulary, Sparb says we might get an attractive drug policy with a $75 co-pay. He wants to balance the whole plan, that's what I think the intent of PERS is in this audit, Kasper wants the audit of the PBMs, and the drug policy, Sparb wants the audit with the PBMs, but he wants to see the whole plan to see what is the best plan.

Chair J. Lee: Those other factors make a difference to what it means to the policy holder. If we move to page two, that's the next part.

V-Chair Larsen: Our BCBS used to have wellness, and then the Sanford policy had that too, then something happened and they pulled it. If he does an audit, and the next audit says they get to go to the gym, so it doesn't matter if it's a little higher.

Chair J. Lee: Sanford Health is bringing the wellness plan back, but the reason it left is the feds decided to tax it, so that the benefit I get if I go to the gym is now a taxable benefit.

Senator Piepkorn: As I understand it, Sanford didn't pull that plan, the PERS Board withdrew.

Chair J. Lee: They wanted to be sure it was clear. They can't slip that in on the policy holders, I don't' have any problem with that, it's going to come again.

Senator Anderson: Administration is difficult for that.

Senator Heckaman: I'm still confused; while it talks about audits, the 1st page has nothing to do with audits. It's the second page, are we putting ourselves in a bind with a-d?

Chair J. Lee: With the amendments, it does talk about an audit, when we add the new language from Sparb's amendment provides the Board or Board's auditor with a copy of the insurers current contract with the PBM. If the contract is revised, that is describing the extent

the board can customize the benefit design, that ties in with the whole audit idea, it's the preference language that's in there.

Senator Anderson: The first section is intended to set parameters that the insurance would provide, the second part is to talk about the audit. Without requiring the parameters in the first section, you don't have anything to audit. That's the reason this doesn't talk about the audit, talks about those stipulations that the plan needs. That's the difference between mandate and preference.

Chair J. Lee: Look at back page of amendment, line 5 (reads language) (25:40-27:25) that lays out how the audit goes.

Senator Anderson: Some of the language is moved down to the bottom, they are essentially the same.

Senator Clemens: You'd mentioned this would leapfrog the board.

Chair J. Lee: If we did it the way Rep. Kasper wants, we would be leapfrogging the insurance company, which the board has a contract with to provide insurance for everybody in the public system. The legislature is able to audit the PBM which is the responsibility of the board to deal with the insurance company. Gave example (28:40-29:30).

Senator Anderson: I think what Senator Clemens is asking in on lines 17 and 18 on page 2 ot the original bill; that's the part Senator Lee doesn't like, we're exempt from the jurisdiction of the Employee Benefits committee, which is different from the board. She doesn't like the idea that we're jumping over them; that's what we're intending to remove.

Senator Clemens: So who is supposedly more in control, the board is in control, the committee is more for recommendations?

Chair J. Lee: Yes. The Employee Benefits committee reviews anything that is considered a mandate for health insurance program. They are supposed to submit mandates by April 1st, so the Employee Benefits Committee can review it so it can come to session with a review, gave the autism example (31:15-31:40).

Senator Clemens: So when it says exempt from the jurisdiction, they're saying they can't have any input.

Chair J. Lee: No, which defeats the purpose of having an Employee Benefits Committee. I have a problem with that.

Senator Clemens: Why wouldn't Rep. Kapser want that? On page 1, line 20 it says replace provide with describes the extent. Rep. Kapser wants the insurance to provide the board with a list of all programs and Collins wants to remove provide and just describe the extent; so the insurance provider is telling the board what to do, correct?

Chair J. Lee: The way the bill reads; it says that the health insurer shall provide the board a list of all programs that will be implemented or modified. The replacement language says

describes the extent to which the board by customize the benefits design including co-payments coinsurances, deductibles and out of pocket limits. Keep in mind that Rep. Kasper sells health insurance, he has his own perspective on it; he has had a problem with PBMs, so do pharmacists. In this case, I don't see why he has a problem with the Employee Benefits Review which is part of the process. I am unlikely to change my mind about the process. I like the fact that there are people on the review. Listed the members of the committee (35:20-35:35).

Senator Clemens: What's the plan?

Chair J. Lee: If you want, I would like for us to look at approving the amendment, subject to review, so that Ian could follow the process here, are we on the same page with the amendments?

Senator Piepkorn: When you say leapfrog Sanford, then you say the responsibility goes back to the legislature to conduct an audit, what does that comprise of?

Chair J. Lee: We as a legislature don't audit, the PERS board runs the program, we are the beneficiaries of the program.

V-Chair Larsen: That would be an outside source, it wouldn't be the auditors in the PERs office.

V-Chair Larsen: I move to adopt Sparb's amendment, with section 2 being deleted.
Senator Kreun: Second.

Senator Piepkorn: I want the mandate rather than the preference

Chair J. Lee: You have to think about being willing to throw the baby out with the bathwater, we have to decide if the rest of it is worth it.

V-Chair Larsen: I was talking with Sparb, and he doesn't seem to think it matters. I do like shining a light on the PBMs, it would be nice to know that we are getting the rebates that are there; I agree with Sparb, they have the ability to do the audit now.

Senator Anderson: I think that Sparb indicated this gives him a little more ability, it's not an industry standard, I'm going to vote against the amendment, my constituency doesn't like the preference language, but I will support the bill.

Senator Clemens: Even with the amendment, you're still going to be satisfied with being able to audit PBMs. Rep. Kasper talked to me early on, his big thing was auditing, seeing what the rebates were; this really won't change that.

Chair J. Lee: It strengthens the ability to pursue that audit, but it doesn't make it a mandate.

Senator Anderson: I hate to do things to boards if we don't have to, we give them the tools to do the right thing, I think this bill will do that. At least then they can't say it's not industry

standard, or it's hard to get a bid; it's a step in the right direction, I'd hate to micromanage Sparb.

Chair J. Lee: If they were doing a lousy job, I might feel differently.

Senator Heckaman: Do you think this will inhibit any of the insurance companies from providing bids?

Senator Anderson: No, I don't. I think they may have a PBM that doesn't want to do this; just say to them we need this information, that's part of the transparency. If the PBMs want our business, they'll step up and provide the information. Workforce Safety and Insurance has a transparent PBM, others can do it too.

A roll call vote was taken.
Motion passes 4-3-0.
V-Chair Larsen: I move Do Pass as Amended.
Senator Kreun: Second.

Senator Piepkorn: Will this go to conference committee?

Chair J. Lee: Yes.

A roll call vote was taken.
Motion passes 5-2-0.
Senator Anderson will carry.

Chair J. Lee: is that your objection Sen. Heckaman, mandate versus preference?

Senator Heckaman: That and we've heard from Sparb, he can already audit.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1403
3/27/2017
Job Number 29725

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to public employee health benefits transparency; and to provide an exemption.

Minutes: 1 attachment

Chair J. Lee: Brought the meeting to order, all members were present.

Chair J. Lee: We have the marked up bill in front of us (**please see attachment #1**), let's review. (0:20-3:15)

Senator Anderson: I sent it to Mike Schwab, he said it looks good, it should give additional tools to auditors when looking at PBMs. He has a question, 'the auditor cannot be a competitor of the PBM', does this mean the only auditor that can be pick is an auditor the PBM wants to use? Each PBM has a list of auditors they don't like. He suggested some language, but I think we should leave it the same as it is.

Chair J. Lee: I'll see if Sparb is available. (He was unavailable; he will contact Sen. Anderson to discuss the language.)

Chair J. Lee: If you're comfortable with your decision, well hold onto this until tomorrow when we have an answer from Sparb.

Senator Piepkorn: Where is the language that addresses my concerns about transparency, that we talked about this morning?

Chair J. Lee: Is that in page 2 at the top, all programs being implemented or modified in including prior authorization, etc. All of that is about transparency. Line 22 describes the audit rights of the board; I think it's good.

V-Chair Larsen: The transparency, the drugs, the formulary, and number of programs implemented. The other part the health and medical part, coinsurance and co-pays is the medical part of that of that audit, that they want to include.

Chair J. Lee: The drugs are covered in the formulary there's a lot of that, the details covered there.

V-Chair Larsen: The member programs implemented, is that the rebate and spread pricing?

Chair J. Lee: Right now the state's getting them.

Senator Clemens: On page 2, line 9, should that be changed to drugs?

Chair J. Lee: Legislative council will take care of that. We'll hold onto this until tomorrow.

Chair J. Lee: Closed the meeting.

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Adopted by the Senate Human Services Committee

March 27, 2017

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

Page 1, line 2, remove "; and to provide an"

Page 1, line 3, remove "exemption"

Page 1, line 9, replace the second "the" with "a"

Page 1, line 9, after the second "coverage" insert "contract received in response to a request for bids under section 54-52.1-04"

Page 1, line 10, replace the second "the" with "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"

Page 1, line 10, remove "with the"

Page 1, line 11, replace "board must include the following terms" with "that"

Page 1, line 12, remove "The insurer shall provide the board with a copy of the insurer's current contract"

Page 1, replace lines 13 through 15 with "Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefit 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."

Page 1, line 16, remove "The health insurer or pharmacy benefit manager shall provide with each invoice"

Page 1, replace lines 17 through 19 with "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"

Page 1, line 20, remove "The health insurer shall provide the board a list of all programs that will be"

Page 1, replace lines 21 through 23 with "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"

Page 2, line 1, remove "(1) The board may retain an auditor of the board's choice which is not a"

Page 2, replace lines 2 through 12 with "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:

CR
~~3/27/17~~
2 of 2
3/27/17

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."

Page 2, line 13, replace "2." with "3."

Page 2, after line 16 insert:

"4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor."

Page 2, remove lines 17 and 18

Renumber accordingly

Date: 3/27 2017

Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1403

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 17.0720.02003

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Larsen Seconded By Sen. Kreun

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman		X
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn		X
Senator Howard C. Anderson, Jr.		X			
Senator David A. Clemens	X				
Senator Curt Kreun	X				

Total (Yes) 4 No 3

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3/27 2017

Roll Call Vote #: 2

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1403

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Larsen Seconded By Sen. Kreun

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman		X
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn		X
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens	X				
Senator Curt Kreun	X				

Total (Yes) 5 No 2

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1403, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1403 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "; and to provide an"

Page 1, line 3, remove "exemption"

Page 1, line 9, replace the second "the" with "a"

Page 1, line 9, after the second "coverage" insert "contract received in response to a request for bids under section 54-52.1-04"

Page 1, line 10, replace the second "the" with "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"

Page 1, line 10, remove "with the"

Page 1, line 11, replace "board must include the following terms" with "that"

Page 1, line 12, remove "The insurer shall provide the board with a copy of the insurer's current contract"

Page 1, replace lines 13 through 15 with "Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefit 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."

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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."

Page 2, line 13, replace "2." with "3."

Page 2, after line 16 insert:

"4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor."

Page 2, remove lines 17 and 18

Renumber accordingly

2017 CONFERENCE COMMITTEE

HB 1403

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/6/2017
29970
☐ Subcommittee
☒ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes:

Rep Ruby: Opens the conference committee on HB 1403.

Sen Lee: The committee preference for the provision to be able to have the option rather than the requirement.

Sen H Anderson: If we require all the audits in the original bid, then if they don't want meet those (inaudible). They felt that the legislation did give them an opportunity to jump over the insurance company & audit that PBM. PERS felt that they could do this now, if they required it in all their contracts, but that's not a standard in the business. The legislation gives them the opt to say, we want to audit the PBM.

Rep Ruby: Speaking with Rep Kasper, his preference would be able to jump to that contractual agreement that PERS would have. We would want to know if there were discounts & things that were being shared with the contract, saving the state money.

If they are going to be the lowest bidder as part of the provisions to avoid the audit. The reason for that is because, not only the cost of the audit, but also there might be more information that wouldn't be revealed with this language. It would be revealed with an audit.

Sen H Anderson: That's a possibility & a concern that things that are promised & paid to the pharmacy are not what was expected.

Rep Ruby: There is that spread & then there any discounts from the pharmaceutical company.

Sen H Anderson: If PERS expected to get that back & then they don't, this audit procedure would allow them to do that. The senate is reluctant to jump in & to say what PERS should have to do. There are some things that PERS feels uncomfortable doing & that might be a mistake.

This legislation gives the PERS the opportunity to find that out. They still have to make the conscience decision that they want to do that. Rep Kasper intent was to force them to do that.

Rep Ruby: They wouldn't have that ability to do that if it's the lowest bid. If they have to take one with this amount of information but they could get bids that would not provide this. That would require the audit. The word preference is the problem because they are always going to have to get preference to a bid that would only go so far. That's a concern we have.

Sen H Anderson: That's the one main issue & the other was the advisory committee to PERS doesn't get to look at. Senate doesn't think that's appropriate when we have that group of mostly legislators.

The two issues are whether it should be a preference or mandatory & the committee.

Rep Ruby: I would like to waive those two issues.

Sen Lee: Would you be willing to ask Sparb to explain the preference portion explained to us at length?

Sparb Collins ~ PERS Board: The difference with the mandatory provision versus a preference. With a mandatory provision, we end up cutting bidders. Some lowest bidders weren't willing to do this but the highest bidder was willing to do this.

Our drug spend is about 18% of our total spend. When you put a package together of health insurance, you are including inpatient/outpatient services & the prescription drugs. So about 80% is the services.

When you weigh a bid put together as a package, you may end up getting a better deal on the 80% than you do on the 20%. If this is mandatory criteria, we make end up being forced to take the highest bid. That's why we put it in as a preference because then you can weigh everything as a full package.

On the audit, page 2, lines 18-25, there was some restructuring, its moved down to line 26 as an addition.

The crux of the bill is page 1, lines 13-14, this is where it became mandatory.

Rep Ruby: If you had the scenario of 3 bidders & 2 didn't want to participate, why would they even submit a bid?

Sparb: You have a minimum requirement of PERS for fully & self-insured that been in statute. It's says that we can only take a self-insured plan if it is lower than the lowest cost fully-insured plan.

Rep Ruby: This preference, isn't that the preference of the bid that deals with the audit?

Sparb: When the bids come in, we are going to give preference to one. We can go in & do these audits. We will say, we will give preference to a bidder who is willing to give us these concessions.

Rep Ruby: Your ability to do audit is only if they are in the contract or would they be under the terms automatically.

Sparb: We argue that we have the ability to do audits under the other provisions. This just enhances the ability.

Rep Ruby: Do you envision that it would be included in every contract.

Sparb: That's what we are saying here, we will give the preference.

Rep Ruby: Could the audit be all-encompassing of the spread pricing or is it limited.

Sparb: We are going to get as much as we can into the contract. One of the questions is the auditing authority, we only get that back money if there is a gain. Gain side, that's to our benefit, but today there is a loss no matter what.

Sen Lee: For the next 2 years, there is no risk to the state, the insurer accepts all the risks in 207-2019. If there is a gain, we get half of the gain.

Sparb: We get even more than that. We share 50/50 in the first 3 million & after that we get it all back.

Sen Lee: In essence, no risk.

Sparb: Correct. It's our advantage to go in & audit because if not all those are coming through, that's not showing up in our gains. This would increase our gains. Now, when we are in a negative environment like we are in today, we would have to find more than 50 million dollars' worth of errors, which you are not going to do when it's only 20% of our business.

Rep Louser: The 3 bids & if these 3 amendments were accepted & none of the 3 bids had the mandatory audit provision included, what changes?

Sparb: That wouldn't be on the table because we wouldn't have anybody. There is no preference to apply here.

Rep Ruby: What provisions when you do an audit you have done in the past that you actually find some funds that should come to the state.

Sparb: Actually there wasn't very many finding in the last one. This bill guarantees confidentiality of the data. When we get an audit we get a summary.

Rep Ruby: The 55 million in the red. You did an audit & you wouldn't get anything because they have to be in the black. If there was a discrepancy, would they still owe that that back & the loss would be more.

Sparb: We have one contract with the carrier. With the carrier we have a segregated account which is the PERS account. That account goes on premium income & out of that account, goes the expenses. There are rebates from the PBMs that they contract with & they go back into the PERS account with the carrier. At the end of the biennium, we take that one account & reconcile that out whether there is a gain or loss. If there is a loss, it goes over to them, not us. If that account is already taking 59-million-dollars loss & we find that there is 2 million dollars in rebates, that account is still taking a loss. Now it's a 57-million-dollar loss & there still is no gain.

Rep Ruby: We will schedule another hearing.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/10/2017
30025
☐ Subcommittee
☒ Conference Committee

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes:

Rep Ruby: Reopens the conference committee on HB 1403.

Rep Ruby: One of the concerns that I still have is it basically gives them authority that they already have to audit. I have a concern with the type of information that was the intent of the bill.

Sen H Anderson: I'm in favor of the harder language. I do think that the current language gives PERS a little bit more because the legislature says, this audit could occur. So that gives them more leverage to compliance from the PBM or makes the insurance company be sure the PBM is doing what they promised. They could audit if they wanted to.

Rep Ruby: If they have the authority, why is it more difficult without the language to request or assert their authority?

Sen H Anderson: They could require this language in their contracts now. With the legislature saying this is standard practice, it gives them more ability to do that.

Sen Heckaman: I don't know if we have authority to hop over the top. This would be the insurance company's job.

Rep Kasper: The PBMs have hidden behind their contractual language for 30 to 40 years. They say the contracts are private and confidential. No one has looked at what is going on behind the scenes. They are making huge profits from the health insurance plans. The PBM is driving the cost and we don't even know it.

An auditor would audit each individual prescription to find what was the dollar amount paid to the pharmacist. What was the dollar amount that the health insurance plan was charged? That results in a spread price. If we don't know what is going on and get the data through an independent audit, which is confidential, we don't know what we are paying extra.

The second area is the rebating. The rebating is negotiated by the PBM with a manufacturer of the drug. The PBM establishes the formulary with their choices. They go to the manufacturer with their choices and negotiate rebates. There are rebates going on in the industry every day. But we don't know how much the rebates are and we don't know where they are going. We are in the blind. As fiduciaries for the health plan for the State of North Dakota, we have the right to find out. The only way to find out is with an audit that knows what they are doing. The original bill was designed to provide the ability for the PERS board to do an audit whether it is a fully insured plan or a self-funded plan. If the language is not written properly for an audit, much of what should be looked at is never disclosed.

There is now legislation in the United States Congress to provide more transparency on PBMs.

The intent of this bill is to require an audit and require that when a company bids for our health plan they must consent to an audit otherwise their bid will not be allowed.

(12:04)
Sen Lee: Do you not think this will have an impact on the number and quality of bids from various providers?

Rep Kasper: It may or may not. When you have a group the size we have with North Dakota PERS, there are companies that will bid. We don't know until we try.

Sen Lee: If we require it, we are going to have challenges in choosing the bid. It sounds like we would be obligated to accept the contract that had a desirable PBM on it even though the rest of the terms of that offer would not be good. I don't think we should be micromanaging a capable board.

Rep Ruby: The amendment that was brought to us kind of does that.

Sen Lee: The reverse is true. If we put the mandate in, it hamstrings them. If we have the preference, they can look at bids and decide what is the best contract. The audit would be part of it. I don't want to tie the hands of the board in determining what is the best net price to the state taxpayers.

Rep Ruby: The preference language is spelled out in the bill as to what would be the preference in a, b, c. Under subsection 2, the board "may conduct annual audits."
"The audits must include:" Then it lists a, b, c. Those are the areas that don't even get close to the information of the audit.

Rep Kasper: The problem is on page 2, line 26 of the colored version. "The board may conduct annual audits to the extent permitted under the contract terms agreed to under subsection 1." That means that if there are no contract terms that allows an audit, there would be no audit All of subsection 2 is worthless. If that were changed to say "The board may conduct annual audits." Then strike "to the extent permitted under the contract terms agreed to under subsection 1." I think we can get there.

Rep Ruby: Would you need more detail under a, b, and c?

Rep Kasper: Yes.

Rep Boschee: I supported the bill in the House version. The concern I have is the process of the PERS bidding. If we have the mandate language and nobody bids, then we don't have a contract. With preferential treatment, it provides the flexibility of the PERS board. The PERS board could authorize language in their own rules. By us mandating in statute, the PERS board has none of that flexibility.

Rep Ruby: Giving that flexibility to change the rule, the people putting the bid in all know that they have that option.

Rep Kasper: Ask your selves one question. PBMs say they are transparent. If that is so, why do they not want to submit to an audit? Why are they fighting so hard? Litigation has shown over the last 15 to 30 years, PBMs have been found guilty of unfair trade practices and close to fraud. This bill from the House is to verify that they are doing things the right way. We can protect the taxpayer's cost.

Sen Heckaman: Why is Section 2 in there? What does that benefit anyone? Why would you exempt this from employee benefits?

Rep Kasper: This is an action of the legislature to require the audit. We don't want to provide an opportunity for an entity that is a subcommittee of the legislature to override what the legislature puts in statute.

Rep Ruby: Isn't there something in statute that says a change to the plan has to go through their employee benefits committee?

(24:17)
Sen Lee: The employee benefits committee meets regularly. It doesn't make decisions. It makes recommendations. That is a deal breaker for me to not have to go through employee benefits. I want to know what Mr. Collins has to say. I also want to visit with some people on the board.

Rep Ruby: Any action?

Rep Kasper: I am working on a new amendment to the bill. I will ask about the impact of the jurisdiction of the employee benefits committee.

Rep Ruby: Adjourns.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/11/2017
30061
☐ Subcommittee
☒ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachments 1, 2, 3, 4

Rep Ruby: Reopens the conference committee on HB 1403.

Rep Ruby: I will ask Rep Kasper to update us.

Rep Kasper: I talked with Jennifer Clark but the amendment is not ready. We are taking out the prohibition for the PERS to have oversight. That's going to be taken out of it. I do have handouts **(attachment 1)**.

The attachment are cases against PBMs that are in litigation from all over the nation. This is for your review. I'm not accusing our PBM of anything but Express Scripts is mentioned many times. There is history of litigation & court cases out there.

Sen Heckaman: Do you know if these were found through fraud units or audits?

Rep Kasper: If you look at the summary, it summarizes the actions. I don't have all the details.

Rep Kasper: This is an article from "Business Insider" & published in September 2016. This talks about the investigation regarding how PBMs conduct business. This is for your information about violations by PBMs. **(Attachment 2).**

Sen Lee: Lawsuits can be found everywhere. The drug pricing issue is with the manufacturers. A big part of our problems is with the manufacturers. With the discounts, rebates & all those kinds of things, I don't know if we will solve that problem by auditing the PBMs. It's a perverse & perverted problem.

Rep Ruby: The reason I supported the bill is it brought light to the different levels.

Sen Lee: There is a fine line between proprietary & transparency that we need to be careful about. I have a great deal of confidence & trust who runs the PERS system. They are doing

their own audits & they are paying attention to what's going on. It's insulting & that they aren't adequate of the job their doing. That is what they are appointed to do.

Rep Ruby: I don't think we said that in anyway. I don't think they know the information that we are seeking.

Rep Kasper: I believe the last time an audit was done was in 2010. The point is, we don't know what has happened with the PBMs & the state plan. The audit will be confidential & it will only go to the people who can analyze it. It's the transparence that's important. I'm not accusing anyone. That's what audits do.

Rep Kasper: Shows how PBMs may operate as to no full disclosure. **(Attachment 3).**

Rep Ruby: We are waiting for amendments.

Sen Lee: I asked the insurance department what kind of action that they might have. **(Attachment 4).**

Rep Kasper: I have talked with the commissioner about what they learned about PBMs. He said nothing. I asked if there was any history of other insurance department having information about PBMs in the past?

Sen Lee: Nobody has filed a complaint with them.

Rep Ruby: Pharmacists have said that they have lost money. This is somewhat confusing & it seems we are not being reimbursed.

Sen Lee: Why are we protecting the pharmacy. We didn't protect the little guy when the big box stores came in. This should not be about protecting pharmacists but PERS functioning properly.

Rep Ruby: I agree, that's why I supported changing our pharmacy ownership law. I don't know in the health care field; you have all those factors.

Rep Kasper: This has nothing to do with the pharmacy, it's about the PBMs.

Sen Heckaman: How many other states audit their PBMs.

Rep Kasper: I believe & assume, all the states because they are self-funded.

Sen Lee: Has the state every thought about doing their own PBM?

Rep Kasper: We have the ability in the MEDICARE or MEDICAID area. Harvey handles the prescription reimbursement through the health department.

Sen H Anderson: What Rep Kasper is referring to is the WSI which has a contract with a PBM. Their contract requires them to be open on all those things.

Rep Ruby: Closes the conference committee.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/13/2017
30104
☐ Subcommittee
☒ Conference Committee

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachment 1

Rep Ruby: Reopens the conference committee on HB 1403.

Jennifer Clark ~ Legislative Council: Goes over the new amendment #17.0720.02006. Attachment 1.

(5:30)
Rep Kasper: If you go to #1, overstruck c, it says "the board may establish a self-insurance plan." It gives the board the option. This gives them the flexibility.

Sen Heckaman: It's my understanding that they already can do that? How would this change what they can already do?

Rep Ruby: With the language in subsection 2 being removed, it gives them more leeway to decide.

Sen Heckaman: I don't see this as a debatable item.

Rep Ruby: It is an explanation as to why that was put in. What we were debating was Section 2.

Sen Heckaman: That is why I don't know if we can address this section because that is not the difference between the two bills.

Rep Ruby: Jennifer, is it germane?

Jennifer Clark: I haven't sat in on your conference committees. One of the items addressed is if your prescription drug component is made a mandatory contract provision vs. a preference that might result in PERS not having options. By giving the board more discretion in this section 1 of the bill, it may address that concern.

Rep Ruby: We have had conversations about the possibility of an audit with a PBM that has a contract with the carrier or whether they have it with the self-funded plan. So we talked about the self-funded components. I thought it was fine with Section 1 being in there.

Jennifer Clark: With our current plan PERS is not a party to that contract with the pharmacy benefit manager. If you look at the language in section 2, it is designed so they could be. If it were under a self-insurance plan, is it possible that PERS could split up that bid? Could they have a bid for traditional health insurance and another bid for the prescription drug? Under our law we allow them to be bid out separately.

Rep Ruby: Section 2, subsections 3c & 4, why do we need to say they have the authority and then they must?

Jennifer Clark: That language in subsection 3, says "the terms of the contract need to provide." Once you codify it, it would behoove whatever state agency you have to include the statutory terms in the contract. Once you enter that contract we are telling PERS what they need to do.

Rep Ruby: That makes sense.

(11:14)
Jennifer Clark: Continues talking about the amendment on attachment 1.

(13:00)
Rep Ruby: Do we need an effective date? The current contract didn't have that language.

Jennifer Clark: I understand there is a contract renewal that has been negotiated. But it hasn't been signed. The PERS board made a decision back in the fall to accept the bid Sanford had. PERS watches the session and then drafts the contract accordingly. Since it is a renewal, it should be very similar to what we have now. The effective date is August 1.

Rep Ruby: Subsection 5 of the amendment, "If an auditor is unable to conduct a complete audit due to lack of access to necessary information, and this noncompliance is not remedied in a timely manner, the board may find the carrier or the pharmacy benefits manager in breach of the contract with the board." What are the consequences of that breach?

Jennifer Clark: You would have to look at each individual contract. The current contract says that if there is a breach, time is given to get back into compliance.

Rep Ruby: So the provisions of the consequences would be in that contract?

Jennifer Clark: I think so.

Sen Lee: I appreciate the efforts of Rep. Kasper. I would like to do some checking and homework.

Sen H Anderson: Can Rep Kasper explain the overall intent?

Rep Kasper: The intent of the amendment is to authorize and require that PERS has the ability to audit the PBM whether it's fully insured or self-funded. The contract that they enter into with the carrier must allow for the audit. I think the audit the first time should be once a year and after that it could be every other year.

Rep Ruby: Audits are not cheap.

Rep Kasper: I'm not set on every year. I'm not suggesting there is anything wrong, but audits many times reveal information that helps save money

Sen Lee: The last audit cost the Department of Human Services $430,000 and used one FTE for a whole year to gather the information. Audits will cost PERS which means the tax payers. Annually is too often and it becomes onerous.

Rep Ruby: Adjourns the meeting.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/14/2017
30141
☐ Subcommittee
☒ Conference Committee

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachment 1

Rep Ruby: Reopens the conference committee on HB 1403.

Rep Kasper: Amendment #17.0720.02007 (Attachment 1)

Rep Ruby: There are two changes.

The first one is starting at the bottom of page 1 and on top of page 2. It establishes self-insurance plan for the hospital medical benefits coverage. "The board shall make individual stop-loss coverage." That means they eliminated it for the PBM if they had a contract with the PBM. That was a concern of the attorney with PERS board. To remove them from the stop-loss requirement was their suggestion.

The second change is at the bottom of page 2 on subsection 4. It says at least biennially the board shall conduct an audit. That takes it from annual to biennial.

Sen Lee: Tell me where is the stop loss coverage?

Chairman Ruby: Last line on page 1 then onto page 2.

Rep Kasper: If we don't try for the emergency clause, this would become effective August 1, 2017. The contract would have already been signed. If we need to clarify that this would be effective at a later date such as August 1 of 2019, we need to discuss that.

Sen Lee: Are you suggesting that you want this to intrude into the contract we currently have?

Rep Kasper: That's the point of not putting a date in.

Sen H Anderson: There are some on the Senate side who would like to see a self-insurance plan. But they weren't happy with starting at six months after the beginning of the biennium. Now it would be clear it would start at the beginning of the next contract period. PERS would

have an opportunity as they start their negotiations almost a year in advance. The objections were the legal ramification of jumping into the middle of a contract. There also is a concern about borrowing the money from the reserve fund.

Rep Kasper: Page 1, number 3, we are stating in the bill that "if the board establishes a self-insurance plan." We are not requiring that they do. We are saying "if they do", it will be established on a two-year contract with an option to renew for two more years. If it's self-insured, it must be bid every four years. Which is a change from the six-year.

Sen Lee: We haven't had a full-session hearing process on this whole discussion. That's the reason for a study. Part of the challenge for any new bidder, if they don't have the potential for the two renewals, that six-year stretch is really important. Why would anyone bid on this?

Section 1, c is new language and gives us heartburn.

Subsection 2, we are giving permission to spend more in order to take a risk. Now we have none. We split the loss up to $3 million. After that we have none. But we have all the gains on this next one and none of the loss. I'm concerned about this when our budget is tight. As far as the audit, what are we going to do with the information.

(9:34)
Chairman Ruby: In subsection c, "if the plan is in the best interest of the state", sometimes the lowest bid isn't always the best bid. It gives them the discretion to pick the best.

I think that is good language because it gives more discretion and authority to the board. We are asking that the audit information be added. It's offering something for both sides.

Sen H Anderson: We don't have risk in the plan right now. But we have to remember we have risk of higher premiums and the reserves were spent down.

Chairman Ruby: Rep Kasper has provided information of what we will learn from the audit.

Rep Kasper: When the audit is done, the auditor will look at the transactions. Their report will be the numbers. They would determine if there was spread pricing. Where are the dollars going? They find information though numbers.

Sen Lee: I can't imagine leaping over the contract with the insurer, that the insurer and the PBM are willing to allow it. The audits the PERS board calls for are important. The cost to do an audit is a large amount of money which is a cost to PERS and ultimately the tax payer. I think it is the responsibility of the PERS board to make sure the terms of the contract are being followed.

Rep Kasper: The PERS board can't get this information. They have to have a consultant to do it. Therefore, they would have nothing to look at. There are firms that specialize in that. You can negotiate an audit whereby the terms would say that whatever dollars the audit saves the plan, the consultant would receive a percentage for their fee. There could be no

cost to the PERS board. The cost has been estimated to be at $100,000. There will be more savings than cost. Right now we know nothing.

Sen Heckaman: Do we need a fiscal note or an employee benefits review?

Rep Kasper: There is no fiscal note now. It is at the discretion of the board whether or not they do the audit. This has already been in front of Employee Benefits earlier in the session. They took no position on the bill.

Sen Lee: Some of this is new language and was not reviewed. I would like to visit with the Employee Benefits board.

Chairman Ruby: As for the fiscal note, it doesn't apply to this biennium and the current contract.

Sen Heckaman: I often see fiscal notes that are extended out to 2019 and 2021.

Chairman Ruby: If there is none this biennium I don't know if they would extend it out. (Requested intern to check if fiscal note needed.)

Chairman Ruby: Closed the conference committee meeting.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/17/2017
30159
☐ Subcommittee
☒ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes:

Rep Ruby: Reopens the conference committee on HB 1403.

Chairman Ruby: Rep Kasper passed out amendments Friday morning & the senate wanted to review it. Senators, your thoughts?

Sen Lee: I visited Rep Kasper & I continue my concerns about mandated coverage. I do appreciate the fact that we have eliminated the bypass of the employee benefits committee.

There are still some concerns. I'm not much interested in having a venue through which we might be talking about self-insured plans when we have a bill already signed by the governor that calls for a study. I think that's the appropriate way to approach this.

If we can get it down to what the issue is at hand & not have it as a vehicle for everything. I would be more comfortable.

Chairman Ruby: Our intention wasn't to usurp the process of the senate's decision to not do the self-funded. This was language that was already in statute & that it was restrictive. If would give the board a little more flexibility, leeway & authority. When they do the next round of bidding, Rep Kasper do you have any comments on that section?

Rep Kasper: Section 1 was to simply designed to clean up the self-insured limitations. It allows, if we ever do become self-insured to accept bids & for the board to make a decision on the merit of the bids. Not simply the one bid had to be cheaper than the other. In some cases, you can't judge exactly up front whether a fully insured bid is cheaper than the self-insured. This cleans the language to give the board the discretion & decision regardless of what the bid numbers are. There is nothing about the audit of the PBM, which is the main focus of the bill.

I talked with Sparb & Jennifer visited about some tweaks to the amendment that introduced on Friday. I was handed some amendments as I was entering today's meeting & I would like some time to look at the amendments based on how it changes this bill. Then at our next

meeting, introduce the follow-up amendments to move the bill forward. I'm not prepared to do that now.

Chairman Ruby: If it was to your liking, could you get the amendment to us before the next meeting?

Rep Kasper: Yes.

Chairman Ruby: Just to add what you have said, Jennifer said this section of code hasn't been touched in a long time. So it needed some cleanup.

Sen Lee: I appreciate that explanation. Was there ever any discussion about those items in any kind of hearing or is it new language to the conference committee?

Chairman Ruby: We did have some discussion but I don't know if it was on this bill about the limitations.

Rep Kasper: That discussion was held in HB 1023 where Rep Carlson introduced some dramatic changes to the make-up of the PERS board moving it to an advisory capacity establishing a legislative committee & requiring that the PERS plan become a self-insured plan. That bill is in conference right now. I don't know where that bill will go & if it doesn't, we can clean it up the language & give the PERS board more options than what we currently have.

Sen Lee: Page 2, section 2, subcontractors 4, is something new. Perhaps it would to wait for the new amendments rather than discussing something that will be changed.

Rep Kasper: I would not object to that.

Chairman Ruby: Closes the hearing.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/18/2017
30184
☐ Subcommittee
☒ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachments 1

Rep Ruby: Reopens the conference committee on HB 1403.

Chairman Ruby: Last thing yesterday was an updated amendment.

Rep Kasper: Attachment 1. There are some minor & important changes, goes over the attachment.

6:30

Sen H Anderson: Page 1, subsection 3, seems to change the current process from a 6 year to a 4 overall year period.

Rep Kasper: This is under the self-funded section which isn't dealing with the PBM, it's dealing with contract the PERS board would enter into. It does state, instead a 6-year contract, it's a 4-year contract with the option to renew.

Section 1 was not in the original bill but it was added to clean up the self-funded section of current statute to make it easier for the PERS board to be able to choose a self-funded plan if they chose.

Sen H Anderson: We added under section 1 in the title, "and prescription drug" benefits, which I like as a pharmacist. But on top of page 2, "establishes a self-insurance plan for hospital & medical benefits", we left the prescription drug coverage out. Was that an oversight?

Rep Kasper: That's on purpose. The reason is the PBM coverage generally are not self-funded. They are a contract on their own.

Chairman Ruby: You can't get stop loss coverage either.

Sen Lee: I have a concern about the fact that I don't think all of this stuff has ever been a part of a regular committee public hearing. Regardless of the merits of section 1, I don't think there was a public hearing on this bill that would have discussed that. I'm asking if there has ever been discussion on the house side of changing it to 4-years instead of 6-years.

Chairman Ruby: Not on this bill, I don't believe there was, but conference committees can discuss issues that are germane to this area of code.

Sen Lee: I believe that the rules on our side of the hall, are that conference committees should be looking at those things that there are differences on the bill. I have a concern of the 4-year/6-year because that is something that we have not talked about in our policy committee. There are several provisions that would be of a concern to me. I also think that in section 2 is micro-managing the board authority to determine what is appropriate in an audit & usurps here.

Rep Kasper: Section 1, HB 1023 is in conference committee now to provide requirement that the PERS board use self-funded health insurance & has had all kinds of discussion about section 1. So that is in that bill.

As far as section 2, the detail was drafted & recommended by a consultant that the PERS board already retained in the past. She is an expert on PBM audits. Her experience is when you do a PBM audit, you must have detail in what you can do, otherwise you don't get to the information you need on an audit. Most of this detail is from her recommendations.

Sen Lee: If the PERS board has hired her as a consultant, that is exactly the reason why we don't need to put this in statute. So to list it in the law is absolutely unnecessary because it's the responsibility of the PERS board to make sure that they are hiring consultants or getting advice from the variety of stake holders in this process.

If I were unhappy of what has been going on with benefits to the covered lives, I would be more agitated. I don't think they have been irresponsible in their efforts to make sure that they are watching over what is going on. This is something PERS should be consulting on to make sure they have the criteria in place that the board thinks is important. I don't distrust the PERS board to make the kinds of decisions that need to be made.

Chairman Ruby: What the house's position is that we wanted an audit done periodically. The language that has been drafted with the interested parties & recommendations form Sparb, give them full authority over to direct the audits. We want to see one & definitely make it as flexible & workable for the senate to accept on that.

Rep Kasper has done a good job with the amendments. We have pretty much been the only ones suggesting changes to try & make this workable.

Rep Kasper: Sparb has seen these amendments & he's ok with these amendments.

Second point, if you look at page 2, number 3, if the terms of the contract are not provided, PBMs don't audit that. That's the reason we need some detail & it doesn't limit them. Again, this has the ok with Sparb.

Sen Heckaman: I would agree with Sen Lee. My concern is the sections 1 & 2 have not had a complete hearing. There are parts in here that I don't know if we need them in here. For me to say this is the right answer to audit a PBM would be me stepping into a deep hole because I don't have the information.

Rep Kasper: We had the hearing in the house on section 2. The bill we sent you was an audit bill about PBMs. So we have had a hearing that you are concerned about in the house. What the senate did was amended the house bill & changed it. You had our bill before you in your committee & had the opportunity to have as much testimony at that podium you desired on the original bill as well the amendment that Sparb proposed. The bill before us now is an amendment to the senate bill that you changed our bill. We did have public hearings & the PBMs were in front of us with discussion as well as other interested parties, particularly on section 2.

Sen Lee: If HB 1023 is where some of this was heard, there should be HB 1023 conferee on this panel but there is not. When we move down to the bottom page 3 where we are talking about the board renegotiating the contract with the existing carrier or pharmacy benefits manager. It's not only the contract with the PBM but with the carrier which would have been breached in a 30-day period.

I not comfortable with this & the senate didn't like the house bill. That's why we amended it. The crux is the mandate & that's the problem. We haven't even had a chance to talk about this in the last two days. That is something important on our side. I want to discuss with my colleagues & Jennifer Clark.

Rep Kasper: Your concern on section 6, the reason language is in there, the existing carrier or the pharmacy benefit manager because under a fully insured plan, you would be negotiating the existing carrier & existing carrier's contract is with the PBM. This covers both cases whether you are fully insured or self-funded for the audit.

Chairman Ruby: Closes the meeting.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/19/2017
30224
☐ Subcommittee
☒ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes: Attachment 1

Rep Ruby: Reopens the conference committee on HB 1403.

Chairman Ruby: There was some discussion on some amendments.

Sen Lee: Attachment 1. Goes over the amendment. We would like to present this for your consideration.

2:12

Rep Kasper: On the 1st line, the board solicits bids for prescription drug coverage, are we eliminating your amendment to a self-insured proposal? In most cases, if we are soliciting bids for a fully-insured plan, we would not have a separate solicitation for a prescription drug because that would be bundled with the fully-insured plan.

Sen Lee: That is the intention & my understanding is that we recognize, no matter what the purpose was, what kind of proposal the board might choose to solicit. They currently have to ability to request any kind of plan. This would enable them to offer preference to a bid that would allow the board to audit those. It says at the bottom," this section applies regardless of whether the prescription drug coverage is bundled with hospital & medical benefits coverage or is in a separate contract". That should cover that.

Rep Kasper: It is the intent of this amendment from your perspective, that they can audit the PBM whether it's fully-insured or self-funded?

Sen Lee: Yes, that's my intent.

Rep Boschee: Does the scoring sheet also have the bonus points on it? If I put in a bid, do I know what my bonus opportunities are? Would it be something giving preference to?

Sen Lee: I don't know if I ever saw a scoring sheet.

Chairman Ruby: In your opinion, do you believe that the board already have this to give the preference or is it on price not preference given to a bid that would allow an audit?

Sen Lee: I believe the board can already do this. But affirming the fact that they have the right to audit the person of the PBM, I'm not interested in mandating that they can bypass the contractual agreement that the carrier has with the PBM. We would be overstepping in my view. If Sen H Anderson has any expertise, I would like him to share.

Sen H Anderson: I think the bill that came over from the senate is better than this amendment as far as giving the PERS board to do that. It sets out some criteria. It certainly doesn't go as far as the house wanted with the criteria.

Sen Lee: I agree.

Chairman Ruby: My concern, if we are just going to put language into the code to give them authorization that they already have. I don't see the need for that. The way it came back from the senate, that seems to be that that's all it did. That is where our position has been.

Sen Heckaman: That's been my point exactly. I haven't liked this bill form day one because I don't think they need any further authority. They already have all the authority they need to do this. I've been opposed to the bill. However, I like amendment .02009 better than .02008 version. If you have to close your nose & vote on something, that would be my choice.

Rep Kasper: Reading the amendment, it's the reverse of the senate version. Under the senate version, the board could give preference to a bid from a fully-insured plan if it did not allow an audit. That's the way I understand the senate's amendment did when they sent it back. The way I read this amendment, it says "the board may give preference to a bid that would allow the board to audit", so I think that the preference is being reversed, which I like because now the preference is on the side of the contract that would allow an audit even if it's fully insured. I like this amendment better than the senate bill.

Sen H Anderson: You said you like the amendment better than the senate bill?

Sen Lee: Is that the way he interprets it; I want to check with the legislative council to see if that's what really is what the goal is. It not to make it that much different. I do prefer what was the .03000 first engrossment which included the senate amendments.

I'm not interested in chatting about fully versus self funded, I'm mostly interested in talking about audits for a PBMs for the board to have the latitude, flexibility & authority that they feel is appropriate. Not for us to do what we think is appropriate.

Chairman Ruby: Comments from the committee?

Sen Lee: Move that the house would accede to the senate amendments.

Sen Heckaman: Second.

Sen Casper: I would like to clarify what Sen Lee just motioned. Is she asking us to accept us to 02009, which was a senate amendment or the bill that was sent to us.

Sen Lee: My motion is that you would accede to the senate amendments in 17.0720.03000 which includes the senate amendments.

Chairman Ruby: Further discussion.

Roll call was taken for the house to accede to the senate amendments with 3 yes, 3 no, 0 absent. Motion failed.

Chairman Ruby: Motion fails, further discussion?

Sen H Anderson: Move the senate recede & amend to amendment .02009.

Rep Boschee: Second.

Chairman Ruby: Further discussion?

Rep Kasper: Would I interpret that the senate could support this amendment once it come back to the full senate chamber?

Sen Lee: My concern is that some questions have been raised & I would like some answers before voting on this, even though it's my amendment. I don't know what my senate body would do. I would prefer to hold the vote.

Chairman Ruby: We do have a motion & a second; we need to withdraw the motion.

Sen H Anderson: I withdraw my motion.

Rep Boschee: I withdraw my second.

Chairman Ruby: Motion is withdrawn. Closes the hearing.

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1403
4/19/2017
30238
☐ Subcommittee
☒ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Public employee health benefits transparency.

Minutes:

Rep Ruby: Reopens the conference committee on HB 1403.

Rep Kasper: Moves the house accede to the senate amendments.

Rep Boschee: Second.

Chairman Ruby: Further discussion?

Sen Lee: I'm not opposing the motion but I was wondering for review if Sparb Collins could go over the amendments that became the .03000 version?

Sparb Collins ~ PERS Board: Re-explains the senate's amendments on version .03000.

Summarized the 4 parts, the preference, may conduct annual audits, confidentiality & retaining of the auditor.

Chairman Ruby: Further discussion.

Roll call for the house to accede to the senate amendment with 5 yes, 1 no, 0 absent. Motion carried.

Date: 4/11/2017
Roll Call: April 6, 10 & 11

2017 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1403 as (re) engrossed

House Industry, Business & Labor Committee

Action Taken

☐ **HOUSE accede to Senate Amendments**
☐ **HOUSE accede to Senate Amendments and further amend**
☐ **SENATE recede from Senate amendments**
☐ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: _____ Seconded by: _____

Representatives	4/6	4/10	4/11	Yes	No	Senators	4/6	4/10	4/11	Yes	No
Rep Ruby	X	X	X			Sen Lee	X	X	X		
Rep Louser	X	—				Sen H Anderson	X	X	X		
Rep Boschee	X	X	Ab			Sen Heckaman	X	X	X		
Rep Kasper	—	X	X								
Total Rep. Vote						Total Senate Vote					

Vote Count Yes: _____ No: _____ Absent: _____

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Date: 4/18/2017
Roll Call: Apr 14, 17, 18

2017 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1403 as (re) engrossed

House Industry, Business & Labor Committee

Action Taken

- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☐ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: _____ Seconded by: _____

Representatives	4/14	4/17	4/18	Yes	No	Senators	4/14	4/17	4/18	Yes	No
Rep Ruby	X	X	X			Sen Lee	X	X	X		
Rep Kasper	X	X	X			Sen H Anderson	X	X	X		
Rep Boschee	X	X	X			Sen Heckaman	X	X	X		
Total Rep. Vote						Total Senate Vote					

Vote Count Yes: _____ No: _____ Absent: _____

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Date: 4/19/2017
Roll Call: 1

2017 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1403 as (re) engrossed

House Industry, Business & Labor Committee

Action Taken

- ☒ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☐ **SENATE recede from Senate amendments and amend as follows**

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen Lee Seconded by: Sen Heckaman

Representatives	4/19			Yes	No		Senators	4/19			Yes	No
Rep Ruby	X				X		Sen Lee	X			X	
Rep Kasper	X				X		Sen H Anderson	X			X	
Rep Boschee	X				x		Sen Heckaman	X			X	
Total Rep. Vote				3			Total Senate Vote				3	

Vote Count Yes: 3 No: 3 Absent: 0

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Move that the house would accede to the senate amendments.

Motion failed

Date: 4/19/2017
Roll Call: 1 held in the pm

2017 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1403 as (re) engrossed

House Industry, Business & Labor Committee

Action Taken

- ☒ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☐ **SENATE recede from Senate amendments and amend as follows**

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Rep Kasper Seconded by: Rep Boschee

Representatives	4/19 pm			Yes	No	Senators	4/19 pm			Yes	No
Rep Ruby	X			X		Sen Lee	X			X	
Rep Kasper	X			X		Sen H Anderson	X			X	
Rep Boschee	X			X		Sen Heckaman	X				X
Total Rep. Vote				3		Total Senate Vote				2	1

Vote Count Yes: 5 No: 1 Absent: 0

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

House accede to the senate amendments.

REPORT OF CONFERENCE COMMITTEE

HB 1403, as engrossed: Your conference committee (Sens. J. Lee, Anderson, Heckaman and Reps. D. Ruby, Kasper, Boschee) recommends that the **HOUSE ACCEDE** to the Senate amendments as printed on HJ pages 1226-1227 and place HB 1403 on the Seventh order.

Engrossed HB 1403 was placed on the Seventh order of business on the calendar.

2017 TESTIMONY

HB 1403

HB 1403
1-24-17
#1

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

House Industry, Business and Labor Committee
HB 1403 – 9:00 A.M.
01/24/17
Chairman Representative George Keiser

Chairman 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 1403.

We have been asked to comment on HB 1403 for the benefit of the State and given our knowledge of Pharmacy Benefit Manager (PBM) practices in the industry, to comment on the language contained in HB 1403.

As you know, audits are a good check and balance – a means to measure a PBMs performance and hold it accountable. Audits serve as a benchmark and provide insight and clarity in determining financial expectations and vendor performance. The most important aspect of auditing a PBM focuses on pricing – verifying that the benefits spelled out in the contract are in fact being provided. The approach of a PBM audit may depend on whether the client has "spread pricing" (where the PBM charges its clients more than the PBM pays the pharmacy for filling a prescription) or "pass-through pricing" (the PBM charges the client the same price the PBM paid the pharmacy) returns in place. I do not know for sure but I believe NDPERS has a traditional PBM contract which allows for price spreading to take place. Depending on what practice or model is being used, will determine what type of claim detail is needed to conduct a thorough audit.

I also do not know but I am assuming any current audit of the PBM is conducted by the health plan carrier (insurer) and not NDPERS. While NDPERS can audit the insurer, they rely on the insurer to audit the PBM and are left in the dark as to the details of the insurer and PBM relationship (contract).

In regards to Section 1.1 – Lines 8-10, it is not clear if the intent is to address instances where NDPERS contracts directly with a PBM (retirees plan) or when NDPERS contracts with an insurer who has a contract with a PBM (commercial NDPERS plan) or both. I assume it is meant to include both but it does not clearly state such.

Section 1.1 a – Lines 11-14, I assume the insurer and PBM will state the contract is confidential and proprietary so they cannot or will not disclose the contract details. While I can respect such a statement, it is not in the best interest of the State or any employer who is paying the bill for that matter. I assume this could be addressed by requesting such disclosure be required in the Request for Proposal (RFP) issued by NDPERS or by this Assembly addressing any potential or perceived issue.

Section 1.1 b – Lines 15-18, we recommend amending this section starting on line 17 "...coverage claims data reflecting all submitted claims, including information fields identified by the board as well as the following informational fields for every claim submitted by a pharmacy to the PBM.

See attachment. Pharmacy claim-by-claim audits are feasible since the data is in an industry standard format. The attachment contains the claim information a plan sponsor truly needs to conduct a thorough audit instead of relying on the information a PBM wants to provide or typically provides.

While certainly not guaranteed, it is not unusual to find savings in excess the cost of the audit. At a minimum, the plan sponsor is rest assured that it has met its fiduciary responsibilities in managing its PBM contract. Again, we support HB 1403 as a matter of good policy and transparency.

I thank you for your time and attention. I would be happy to try and answer any questions.

Respectfully Submitted,

Mike Schwab

Mike Schwab
EVP – ND Pharmacists Association

Exhibit A

The following information fields shall be provided for every claim submitted by a pharmacy to the PBM:

HICN – Health Insurance Claim Number
Patient Date of Birth (DOB)
Patient Gender
Service Provider Qualifier
Service Provider Number Prescriber Identifier Qualifier
Prescriber Identifier
DAW
Fill #
Dispensing Status
Drug Coverage Status Code (Partial or Completion or blank)
Catastrophic Coverage Code - Attachment Point met on this event, Above Attachment Point, or attachment point not met
GDCB – Gross Drug Cost Below OOP Threshold
GDCA – Gross Drug Cost Above OOP Threshold
TrOOP Amt – True Out of Pocket Amount
Other TrOOP Amt - Other payments by TrOOP eligible payers
LIC Status – Low Income
LIC Amt – Low Income Cost Sharing Subsidy Amount
CPP – Covered Plan Paid
NPP – Non Covered Plan Paid
Received Date of Original Claim
Claim Adjudication Began Timestamp/Date
Total Gross Covered Item Cost Accumulator
True TrOOP Accumulator
Brand/Generic Code
Beginning Benefit Phase
Ending Benefit Phase
Tier
Formulary Code (for vaccine administration fee only)
Reported Gap Discount
Mail/retail/specialty indicator

Unique claims identifier
Unique claims identifier cross-reference (for reversals)
Claim status
Client subaccounts (carrier, group)
Date submitted
Date filled
Cycle Date
Rx#
Refill #
Compound Code
Plan Beneficiary Submitted Identifier
NDC#
Drug Description
Metric Decimal Quantity
Days' Supply
DAW Code
Network Contract Identifier
Pharmacy Number (NABP or NPI)
Pharmacy Name
Unit AWP Used
Usual and Customary
Pharmacy Ingredient Cost
Pharmacy Dispensing Fee
Pharmacy Sales Tax
Pharmacy Patient Pay
Pharmacy Amount Due
Pharmacy Basis of Adjudication
Client Basis of Adjudication
Client Ingredient Cost Paid
Client Dispensing Fee Paid
Client Sales tax
Client Patient Pay
Client Amount Due
COB Indicator
COB Amount

PA#
Reject Code1
Reject Code2
Reject Code3
Member ID and Person Code or Patient ID

HB 1403 1
#2
1-24-17

Patrick Ward

From: Patrick Ward
Sent: Sunday, January 22, 2017 9:04 AM
To: 'Kasper, Jim M.'
Cc: Patrick Ward; John Ward
Subject: Proposed amendments to HB 1403 prior to hearting hearing Tuesday morning

Hi Jim:

I have reviewed your proposed bill with my PBM client.

I think we can support the bill with a few minor changes in paragraph 1(d)(2). See changes in red below.

Pat

Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

(2) The board may conduct annual audits of ~~the to verify~~ the pharmacy benefit ~~manager is satisfying~~ services agreement ~~the terms of its contract~~ with the health insurer; assess the costs resulting from the health insurer's contract with the pharmacy benefit manager and make recommendations as to amendments in that contract which would decrease costs; and assess the programs being implemented and make recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment.

http://www.legis.nd.gov/assembly/65-2017/documents/17-0720-01000.pdf

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Proposed Amendment to HB 1403

Pat Ward, H-IBL
January 24, 2017

Page 2, line 5, remove "to verify" and replace with "of"

Page 2, line 6, remove "manager is satisfying" and replace with "services agreement"

Page 2, line 6, remove, "the terms of its contract."

Jan 30, 2017

1

17.0720.01001
Title.

Prepared by the Legislative Council staff for
Representative Kasper
January 25, 2017

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1403

Page 1, line 2, after "transparency" insert "; and to provide an exemption"

Page 2, after line 16, insert:

"**SECTION 2. EXEMPTION.** This Act is exempt from the jurisdiction of the employee benefits programs committee under section 54-35-02.4."

Renumber accordingly

NDPERS

HB 1403

TESTIMONY OF NDPERS
HOUSE BILL 1403

Mr. Chairman, members of the committee my name is Sparb Collins. I am the Executive Director of the North Dakota Public Employees Retirement System (NDPERS). I appear before you today on behalf of the PERS Board and in a neutral position on this bill. I have attached for your information and consideration, a review conducted on this bill by our consultant and which includes their suggestions.

I would also like to offer a suggestion from the PERS Board. They are proposing that this become a "preference criteria" in selecting a vendor or vendors for the health plan. As presently worded, it is our interpretation that if a vendor would not agree to these provisions, we would be unable to select them regardless of other variables. The implications of this could be:

1. That if we only had one vendor bid and they did not agree to these terms we may not be able to award the plan in a timely manner.
2. That we get more than one bid, but the one willing to accept these terms could be significantly higher priced and we would be required to accept them.

If this is a preference criterion, the board could consider the entire scope of the responses. Also, it would be helpful if the board was provided discretion to negotiate these provisions and use them as a guide. For example, if we were able to get a vendor to agree to substantially most of these requirements, or the intent of these requirements, but in a different form, it would be helpful to allow the discretion to accept that offer.

As preference criteria, the above could be accommodated.

Thank you Mr. Chairman and members of the committee, this concludes my testimony. If can assist you with your considerations, please let me know.

Deloitte.

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Memo

Date: January 23, 2017

To: Senator Krebsbach, Chair
Legislative Employee Benefits Programs Committee

From: Josh Johnson and Drew Rasmussen, Deloitte Consulting LLP

Subject: REVIEW OF PROPOSED BILL 17.0720.01000 (HB1403) REGARDING HEALTH INSURANCE BENEFITS COVERAGE – PRESCRIPTION DRUG COVERAGE – TRANSPARENCY – AUDITS - CONFIDENTIALITY

The following summarizes our review of the proposed legislation.

OVERVIEW OF PROPOSED BILL

The proposed bill would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that for health insurance benefits contracts that use a pharmacy benefits manager ("PBM") the insurance contract between the health insurer and the PBM must be disclosed to the board. Further, all invoices must contain the corresponding pharmacy claims, clinical and utilization management programs must be disclosed prior to implementation, audit rights must include the ability to select an auditor and conduct annual audits of the PBM.

COMMENTARY ON PROPOSED BILL

Section 1.1 (page 1, lines 8-10)

Proposed language:

"If the prescription drug coverage of the health insurance benefits coverage utilizes the services of a pharmacy benefits manager, the insurer's contract with the board must include the following terms:"

Comments: We recommend specifying the language if the intent is to address instances where a health insurer contracts with a PBM for pharmacy services (i.e. Sanford and Express Scripts) or if the board contracts directly with a PBM for services (i.e. a "carve-out" contract).

Revised language recommendation: "If the prescription drug coverage of the health insurance benefits coverage utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, the contract provisions that include pharmacy benefits administration with the board must include the following terms:"

Section 1.1.a (page 1, lines 11-14)

Proposed language:

"The insurer shall provide the board with a copy of the insurer's current contract with the pharmacy benefit management company and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract"

Comments: We recommend clarifying the intent of this provision. If the intent is to review the contract agreement between the health insurer and the PBM, it is unlikely that either entity will agree to share their contract with the board. The insurer and the PBM will deem the contract proprietary.

If the intent of the provision is to review the pharmacy benefits contract agreement between the health insurer and/or PBM and the plan sponsor (the board) then the language could be modified to address this requirement directly.

Revised language recommendation: "The entity contracted for pharmacy benefits insurance coverage shall provide the board with a copy of the contract between the insurer and the plan sponsor, and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract"

Section 1.1.b (page 1, lines 15-18)

Proposed language:

"The health insurer or pharmacy benefit manager shall provide with each invoice statement and for each annual audit a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board"

Comments: We recommend receiving claims from the prescription drug provider on a monthly basis, consistent with current practice. This allows for all claims to be finalized before they are submitted for Data Warehousing. It also allows for appropriate comparison and reconciliation of the invoices to the paid pharmacy claims.

Revised language recommendation: "The health insurer or pharmacy benefit manager shall provide monthly and for each annual audit a complete set of electronic prescription

coverage claims data reflecting all submitted claims, including information fields identified by the board"

Section 1.1.c (page 1, lines 19-22)

Proposed language:

"The health insurer shall provide the board a list of all programs that will be implemented, including prior authorization programs, step therapy programs, quality limit programs, and mandatory generic programs. The list must include the drugs in each program and the specifics about each drug."

Comments: We recommend changing "quality limits" to "quantity limits" (likely an auto-correct).

We recommended clarifying what information is being requested for "the specifics about each drug". It would be helpful to clarify if the intent is to request the rationale for including each drug in the program, the anticipated disruption to members, expected cost avoidance, and/or details about each drug such as NDC Number, Drug Strength, Drug Indication, ect.

Revised language recommendation: "The health insurer shall provide the board a list of all programs that will be implemented, including but not limited to: prior authorization programs, step therapy programs, quantity limit programs, and mandatory generic programs. The list must include the drugs in each program, the cost of the program, the anticipated member disruption, process for override (if applicable), anticipated cost savings (or cost avoidance), performance guarantees (if applicable), and anticipated clinical outcomes."

Section 1.1.d (1) (page 2, lines 1-4)

Proposed language:

"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"

Comments: No comments, we agree with the provision as written.

Section 1.1.d (2) (page 2, lines 5-12)

Proposed language:

"The board may conduct annual audits to verify the pharmacy benefit manager is satisfying the terms of its contract with the health insurer; assess the costs resulting from the health insurer's contract with the pharmacy benefit manager and make recommendations as to amendments in that contract which would decrease costs; and

assess the programs being implemented and make recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment."

Comments: We recommend clarifying if the intent is to audit the terms between the health insurer and the PBM or to audit the terms between the pharmacy benefits insurer and the plan sponsor.

Assessments of the clinical and/or utilization management programs should happen annually as part of the review process with the PBM. An audit of the terms of the contract may only result in the affirmation that a program is in place but might not lead to recommendations as to the outcomes of the program related to clinical outcomes or avoided cost.

Revised language recommendation: "The board may conduct annual audits to verify the pharmacy benefit provider is satisfying the terms of its contract with the plan sponsor; assess the costs resulting from the pharmacy benefit contract with the plan sponsor and make recommendations as to amendments in that contract which would decrease costs. The board requires, at minimum, annual review of the operational, clinical, and financial outcomes of the programs implemented and recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment."

Section 2 (page 2, lines 13-16)

Proposed language:

"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."

Comments: No comments, we agree with the provision as written.

Drug Benefit Managers Need More Oversight, Pharmacists Say

by **Jared S Hopkins**
February 27, 2017 2:30 PM
Updated on February 27, 2017 5:20 PM

- → Letter to HHS says pharmacy middlemen operate in 'black box'
- → PBM group says pharmacists' proposals will raise costs

Middlemen who manage drug benefits for employers and insurers should be under greater government oversight of their pricing and billing practices to make health care cheaper, an independent pharmacists' group said.

President Donald Trump's plans to lower prescription drug costs will only succeed if greater transparency is imposed on pharmacy benefit managers, the group said in a letter <http://www.ncpa.co/pdf/2-16-17-hhs-sec-letter.pdf> to Health and Human Services Secretary Tom Price that was released Monday. PBMs include CVS Health Corp., which also operates retail pharmacies, and Express Scripts Holding Co.

Benefit managers engage in price negotiations that are often kept secret for competitive reasons, with manufacturers on one end and pharmacies on the other. Pharmacists have criticized these discussions, as well as so-called clawbacks <https://www.bloomberg.com/news/articles/2017-02-24/sworn-to-secrecy-drugstores-stay-silent-as-customers-overpay> -- extra profit for the PBM after co-pays for cheap, generic medicines exceed the price of the drug itself. Some middlemen prohibit pharmacies from telling customers about the clawbacks, and the practice has sparked at least 16 federal lawsuits.

PBMs "continue to operate in a virtual black box," according to the letter dated Feb. 16. It was signed by Doug Hoey, Chief Executive Officer of the National Community Pharmacists Association.

Trump's Impact

The Pharmaceutical Care Management Association, a PBM trade group, said its practices lead to greater savings, while the pharmacists' proposals will lead to higher costs. The group is sponsoring a media campaign emphasizing that the "wrong kind" <http://drugbenefitsolutions.com/what-is-drug-price-transparency/> of transparency allows drugmakers to collude on price, ultimately hurting consumers.

"PBMs will save consumers, employers, unions, and government programs $654 billion over the next decade," Mark Merritt chief executive of the PBM trade group said. "Meanwhile, the independent drugstore lobby agenda would raise costs for seniors, employers, and programs like Medicare Part D."

Trump is promising to lower drug costs, saying the government should get better prices, and the pharmaceutical industry is "getting away with murder." As the outcry over drug pricing intensifies, the middlemen have gained more attention.

You're Overpaying for Drugs and Your Pharmacist Can't Tell You

by **Jared S Hopkins**
February 24, 2017 4:00 AM
Corrected February 27, 2017 10:21 AM

- Gag clauses stop pharmacists from pointing out a cheaper way
- Cigna, UnitedHealth and Humana face at least 16 lawsuits

Eric Pusey has to bite his tongue when customers at his pharmacy cough up co-payments far higher than the cost of their low-cost generic drugs, thinking their insurance is getting them a good deal.

Pusey's contracts with drug-benefit managers at his Medicap Pharmacy in Olyphant, Pennsylvania, bar him from volunteering the fact that for many cheap, generic medicines, co-pays sometimes are more expensive than if patients simply pay out of pocket and bypass insurance. The extra money -- what the industry calls a clawback -- ends up with the benefit companies. Pusey tells customers only if they ask.

"Some of them get fired up," he said. "Some of them get angry at the whole system. Some of them don't even believe that what we're telling them is accurate."

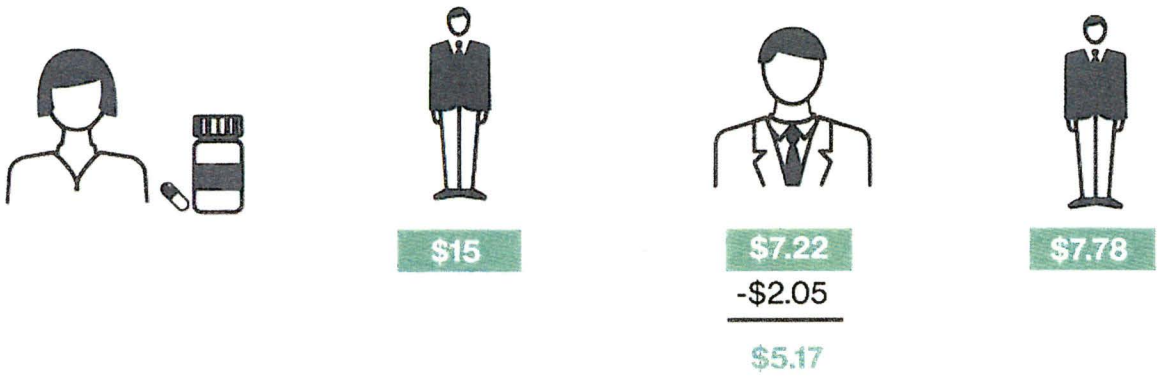
Clawbacks Work Like This:

1. Customer is prescribed 40 milligrams of the stomach medicine pantoprazole.

2. The pharmacy benefit manager has helped negotiate a $15 co-payment for generic pantoprazole. The medicine costs the pharmacist $2.05.

3. The pharmacist is reimbursed $7.22, giving him a profit of $5.17.

4. The benefit manager "claws back" $7.78 from the pharmacy.



Update: Feb. 27: Corrects dosage
Source: Bloomberg research

Bloomberg

Clawbacks, which can be as little as $2 a prescription or as much as $30, may boost profits by hundreds of millions for benefit managers and have prompted at least 16 lawsuits since October. The legal cases as well dozens of receipts obtained by Bloomberg and interviews with more than a dozen pharmacists and industry consultants show the growing importance of the clawbacks.

"It's like crack cocaine," said Susan Hayes, a consultant with Pharmacy Outcomes Specialists in Lake Zurich, Illinois. "They just can't get enough."

The cases arrive at a critical juncture in the quarter-century debate over how to make health care more affordable in America. President Donald Trump is promising to lower drug costs, saying the government should get better prices and the pharmaceutical industry is "getting away with murder." The Pharmaceutical Care Management Association, a benefits-manager trade group, says it expects <https://www.bloomberg.com/news/articles/2017-02-08/seeing-danger-of-trump-s-new-thing-health-group-preps-defense> greater scrutiny over its role in the price of medicine and wants to make its case "vocally and effectively."

Racketeering Accusations

Suits have been filed against insurers UnitedHealth Group Inc. <https://www.bloomberg.com/quote/UNH:US>, which owns manager OptumRx; Cigna Corp. <https://www.bloomberg.com/quote/CI:US>, which contracts with that manager; and Humana Inc. <https://www.bloomberg.com/quote/HUM:US>, which runs its own. Among the accusations are defrauding patients through racketeering, breach of contract and violating insurance laws.

"Pharmacies should always charge our members the lowest amount outlined under their plan when filling prescriptions," UnitedHealthcare spokesman Matthew Wiggin said in a statement. "We believe these lawsuits are without merit and will vigorously defend ourselves."

Mark Mathis, a Humana spokesman, declined to comment. Matt Asensio, a Cigna spokesman, said the company doesn't comment on litigation.

"Patients should not have to pay more than a network drugstore's submitted charges to the health plan," Charles Cote, a spokesman for the Pharmaceutical Care Management Association, said in a statement.

Read more: Escalating U.S. drug prices -- a QuickTake explainer <https://www.bloomberg.com/view/quicktake/drug-prices>

Benefit managers are obscure but influential middlemen. They process prescriptions for insurers and large employers that back their own plans, determine which drugs are covered and negotiate with manufacturers on one end and pharmacies on the other. They have said

their work keeps prices low, in part by pitting rival drugmakers against one other to get better deals.

The clawbacks work like this: A patient goes to a pharmacy and pays a co-pay amount -- perhaps $10 -- agreed to by the pharmacy benefits manager, or PBM, and the insurers who hire it. The pharmacist gets reimbursed for the price of the drug, say $2, and possibly a small profit. Then the benefits manager "claws back" the remainder. Most patients never realize there's a cheaper cash price.

"There's this whole industry that most people don't know about," said Connecticut lawyer Craig Raabe, who represents people accusing the companies of defrauding them. "The customers see that they go in, they are paying a $10 co-pay for amoxicillin, having no idea that the PBM and the pharmacy have agreed that the actual cost is less than a dollar, and they're still paying the $10 co-pay."

On Feb. 10, a customer at an Ohio pharmacy paid a $15 co-pay for 40 milligrams of generic stomach medicine pantoprazole that the pharmacist bought for $2.05, according to receipts obtained by Bloomberg. The pharmacist was repaid $7.22, giving him a profit of $5.17. The remaining $7.78 went back to the benefits manager.

Opaque Market

Clawbacks are possible because benefit managers take advantage of an opaque market, said Hayes, the Illinois consultant. Only they know who pays what.

In interviews, some pharmacists estimate clawbacks happen in 10 percent of their transactions. A survey by the more than 22,000-member National Community Pharmacists Association found 83 percent of 640 independent pharmacists had at least 10 a month.

"I've got three drugstores, so I see a lot of it," David Spence, a Houston pharmacist, said in an interview. "We look at it as theft -- another way for the PBMs to steal."

Lawsuits began in October in multiple states, and some have since been consolidated. Most cite an investigation by New Orleans television station Fox 8, which featured interviews with Louisiana pharmacists whose faces and voices were obscured.

Tight Restrictions

Many plans require pharmacies to collect payment when prescriptions are filled and prohibit them from waiving or reducing the amount. They can't even tell their customers about the clawbacks, according to the suits. Contracts obtained by Bloomberg prohibit pharmacists from publicly criticizing benefit managers or suggesting customers obtain the medication cheaper by paying out of pocket.

Pharmacists who contract with OptumRx in 2017 could be terminated for "actions detrimental to the provider network," doing anything that "disparages" it or trying to "steer" customers to other coverage or discounted plans, according to an agreement obtained by Bloomberg.

"They're usually take-it-or-leave-it contracts," said Mel Brodsky, who just retired as chief executive officer of Pennsylvania's Keystone Pharmacy Purchasing Alliance, which buys drugs on behalf of independent pharmacies.

OptumRx is among the three largest benefit managers that combine to process 80 percent of the prescriptions in the U.S. The other two, Express Scripts Holding Co. <https://www.bloomberg.com/quote/ESRX:US> and CVS Caremark, haven't been accused of clawbacks. CVS doesn't use them, it said in a statement. Express Scripts is so opposed that it explains the practice on its website <http://lab.express-scripts.com/lab/insights/drug-options/keeping-copays-affordable> and promises customers will pay the lowest price available.

Potential Death Blow

Pharmacies fear getting removed from reimbursement networks, a potential death blow in smaller communities. But some pharmacists jump at opportunities to inform customers who question their co-pay amounts.

"Most don't understand," said Spence, who owns two pharmacies in Houston. "If their co-pay is high, then they care."

States are responding. Last year, Louisiana began allowing pharmacists to tell customers how to get the cheapest price for drugs, trumping contract gag clauses. In 2015, Arkansas

prohibited benefit managers and pharmacies from charging customers more than the pharmacy will be paid.

"The consumers don't know what's going on," said Steve Nelson, a pharmacist in Okeechobee, Florida. "We try to educate them with regards to what goes into a prescription, OK? You've got to kind of tip-toe around things."

(Corrects drug dosage in 14th paragraph, graphic.)

BREAKING: Generic Drug Payment Transparency Bill Dropped in House Today | eNews | March 2, 2017

by NCPA | Mar 02, 2017

ADVOCACY NEWS

BREAKING: Generic Drug Payment Transparency Bill Dropped in House Today

Bipartisan legislation to increase transparency in generic drug payments in taxpayer-funded federal health programs and preserve patient access to local community pharmacies was introduced in the House this morning by Reps. Doug Collins (R-Ga.) and Dave Loebsack (D-Iowa) and endorsed by NCPA. Original cosponsors of the legislation include Reps. Brian Babin (R-Texas), Rod Blum (R-Iowa), John Duncan (R-Tenn.), Cathy McMorris-Rodgers (R-Wash.), John Sarbanes (D-Md.), and the only pharmacist currently serving in Congress, Buddy Carter (R-Ga.).

H.R. 1316, the Prescription Drug Price Transparency Act, is similar to legislation introduced in the 114th Congress in 2015. It would require PBMs to provide updates to pharmacies for maximum allowable costs lists and set a standard for how frequently those lists are updated. Read the fact sheet about the legislation.

Contact your representative and ask him or her to sign on as a cosponsor of this critical legislation. Visit the **NCPA Legislative Action Center** to send him or her an email, and be sure to register for the **NCPA Congressional Pharmacy Fly-In** April 26-27 in Washington, D.C., and ask for their support in person.

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In House Speeches, Pharmacy Champions Expose PBMs' Role in Higher Rx Prices

Led by Rep. Doug Collins (R-Ga.), pharmacy champions took to the House floor yesterday to denounce PBM tactics that are hurting patients and pharmacies. Community pharmacies "are under constant threat of going out of business because of PBMs," Collins declared, speaking in the House chamber. "PBMs exploit the market, prey on community pharmacists using spread pricing and retroactive DIRs. They also use a disproportionate share of the market to steer patients to pharmacies they own themselves."

Collins was joined during the one-hour "special order" by Reps. Brian Babin (R-Tex.), Buddy Carter (R-Ga.), John Duncan (R-Tenn.), Dave Loebsack (D-Iowa), and Austin Scott (R-Ga.). Rep. Pete Sessions (R-Tex.) submitted a statement and Rep. Cathy McMorris Rodgers (R-Wash.) was among the lawmakers who tweeted their support. Follow NCPA on Twitter to see tweets and retweets on the speeches.

Watch the speeches on C-SPAN and visit NCPA on Facebook.

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Eye on PBMs

The video and articles linked below help explain some of the confusing

and opaque PBM practices you face every day. Share them on your Facebook, Twitter, and other social media accounts to help your friends and followers understand the impact PBMs have on patients and pharmacies. And, ICYMI, read about pizzas and a different kind of PBM.

- The 11Alive Investigators—Side Effects: The Middlemen
- The 11Alive Investigators—Side Effects: The Middlemen Part 2
- Drug Benefit Managers Need More Oversight, Pharmacists Say
- You're Overpaying for Drugs and Your Pharmacist Can't Tell You

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✚ Tell Capitol Hill to End PBM Abuses

If you're not sitting at the table, you could be on the menu. Don't be the PBMs' dinner! Come to Washington April 26-27 for the **NCPA Congressional Pharmacy Fly-In** and tell your elected officials in person why Congress needs to rein in PBMs' abusive practices. In-person meetings are the most compelling way to make our message heard on Capitol Hill, so we've made the event much shorter and more affordable this year so you can come to Washington and meet with decision-makers. The Hilton Alexandria will serve as the anchor hotel, but we do not have a room block. That gives you more flexibility to choose a hotel that suits your needs (find a list of hotel options on the NCPA website). Register now online or by calling 1-800-544-7447 and fight for community pharmacy. All it takes is one day and your voice.

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PHARMACY SOLUTIONS

✚ Earn CE on a March 8 Webinar: Setting Up a Travel Immunization Niche

With international travel continuing to increase exponentially and many travelers visiting destinations that require vaccinations, the potential in this niche gives community pharmacies an opportunity for growth not just in vaccines, but in ancillary services as well. Join the NCPA Innovation Center's March 8 live webinar for a pharmacy owner's perspective on the opportunities from marketing and detailing to delivery and follow-up in the travel immunization niche. The webinar is FREE and open to all pharmacists. (CE credit available only to those participating in the entire live webinar.)

NCPA Members Forum: Immunizations Beyond Flu
Date: March 8 at 2 p.m. ET
Speaker: Justin Wilson, PharmD, Valu-Med Pharmacy, Midwest City, Okla.
Advance registration is required. Please contact Sue Hagler at sue.hagler@ncpanet.org with any questions.

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✚ Back by Popular Demand: Re-Engineering Your Pharmacy Boot Camp—Save $$ By Registering Early!

Changes in health care and payment reform have brought about new opportunities for community pharmacy. The **NCPA Innovation Center's Re-Engineering Your Pharmacy Boot Camp** is a peer-led immersion course designed to help you navigate the management of an enhanced service pharmacy. The Boot Camp will be held May 5-6 in the New York City metro area. From motivating your staff and taking on new

responsibilities to business planning for enhanced services, this program has it all. Take your pharmacy to the next level in this high-energy program. Register now and save $50!

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Pharmacy Technician Certification Exam Recently Approved in Three States

NCPA recognizes the Examination for the Certification of Pharmacy Technicians (ExCPT) as an excellent assessment of competency for entry-level pharmacy technicians. ExCPT was recently approved by the boards of pharmacy in California, Arizona, and Texas. Through certification, pharmacy technicians demonstrate knowledge and competency in the core tasks they will be performing, which in turn enhances patient safety. The National Healthcareer Association (NHA) has awarded over 650,000 certifications to allied health professionals, including pharmacy technicians.

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PBM Toolkit

Long-Term Care Division

Generic Drug Pricing Transparency in Federal Health Programs

MAC legislation would protect taxpayer funds, help independent community pharmacies

Background
Generic prescription drugs account for over 80 percent of medications dispensed by community pharmacies, yet there is no transparency into how they are priced in federal health programs by middlemen called pharmacy benefit managers (PBMs). Through hidden **maximum allowable cost (MAC) lists**, PBMs can overcharge federal health programs while paying much lower reimbursement rates to independent community pharmacies.[1] In order to care for patients, independent community pharmacies must accept take-it-or-leave-it contracts, which let PBMs dictate MAC reimbursement rates that are at times below-cost or fail to keep up with inflation.[2]

Solution: Increase transparency and oversight of MAC pricing in federal health programs by PBMs.
The Prescription Drug Price Transparency Act (H.R. 1316) would bring clarity to generic drug payments in Medicare Part D, TRICARE, and the Federal Employee Health Benefits (FEHB) Program. Congress should enact H.R. 1316 to:

- **Ensure effective oversight of taxpayer dollars in federal health programs**. H.R. 1316 would enhance program integrity and establish MAC as a drug pricing standard.
- **Encourage utilization of cost-saving generic drugs whenever appropriate**. H.R. 1316 would support fair reimbursement and incentivize community pharmacists to actively promote generic drugs to cut costs. Pharmacists' generic recommendations are accepted 95 percent of the time by physicians.[3]
- **Support access to independent community pharmacies**. H.R. 1316 would give community pharmacies insight into the basis for MAC reimbursement rates, certainty that they are updated to reflect real-world prices (at least every seven days), and an effective appeals process to contest below-cost payments.
- **Protect patient choice of pharmacy**. H.R. 1316 would prohibit PBM corporations from requiring patients use the mail order and specialty pharmacies they own, which creates a conflict of interest, or exploiting private patient data for those purposes.

H.R. 1316 WILL NOT increase federal costs. The legislation simply allows for greater transparency into PBM generic drug pricing benchmarks and predictability for community pharmacies. It does not establish reimbursement rates and leaves that authority to health plan sponsors or their designees, such as PBMs.

Bipartisan precedent in state laws across the country. H.R. 1316 is comparable to similar to legislation overwhelmingly enacted in 33 states.

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[1] "Painful prescription", 2013,
[2] "Pharmacist Survey Raises Concerns for Patient Access to Generic Drugs," 2015,
[3] *2016 NCPA Digest, sponsored by Cardinal Health*

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Senate Human
Services Committee
HB 1403 Testimony
March 7, 2017
NDPERS

Red River Room

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3/7
Pg.1

TESTIMONY OF NDPERS
HOUSE BILL 1403

Madame Chair, members of the committee my name is Sparb Collins. I am the Executive Director of the North Dakota Public Employees Retirement System (NDPERS). I appear before you today on behalf of the PERS Board and in a neutral position on this bill. I have attached for your information and consideration, a review conducted on this bill by our consultant, and which includes their suggestions.

I would also like to offer a suggestion from the NDPERS Board. They are proposing that this become a "preference criteria" in selecting a vendor or vendors for the health plan. As presently worded, it is our interpretation that if a vendor would not agree to these provisions, we would be unable to select them regardless of other variables. The implications of this could be:

1. That if we only had one vendor bid and they did not agree to these terms we may not be able to award the plan in a timely manner.
2. That we get more than one bid, but the one willing to accept these terms could be significantly higher priced and we would be required to accept them.

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As preference criteria, the above could be accommodated.

Thank you Madame Chair and members of the committee, this concludes my testimony. If I can assist you with your considerations, please let me know.

1403
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3/1
Pg.2

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Memo

Date: January 23, 2017

To: Senator Krebsbach, Chair
Legislative Employee Benefits Programs Committee

From: Josh Johnson and Drew Rasmussen, Deloitte Consulting LLP

Subject: REVIEW OF PROPOSED BILL 17.0720.01000 (HB1403) REGARDING HEALTH INSURANCE BENEFITS COVERAGE – PRESCRIPTION DRUG COVERAGE – TRANSPARENCY – AUDITS – CONFIDENTIALITY

The following summarizes our review of the proposed legislation.

OVERVIEW OF PROPOSED BILL

The proposed bill would create a new section to chapter 54-52.1 of the North Dakota Century Code mandating that for health insurance benefits contracts that use a pharmacy benefits manager ("PBM") the insurance contract between the health insurer and the PBM must be disclosed to the board. Further, all invoices must contain the corresponding pharmacy claims, clinical and utilization management programs must be disclosed prior to implementation, audit rights must include the ability to select an auditor and conduct annual audits of the PBM.

COMMENTARY ON PROPOSED BILL

Section 1.1 (page 1, lines 8-10)

Proposed language:

"If the prescription drug coverage of the health insurance benefits coverage utilizes the services of a pharmacy benefits manager, the insurer's contract with the board must include the following terms:"

Comments: We recommend specifying the language if the intent is to address instances where a health insurer contracts with a PBM for pharmacy services (i.e. Sanford and Express Scripts) or if the board contracts directly with a PBM for services (i.e. a "carve-out" contract).

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Revised language recommendation: "If the prescription drug coverage of the health insurance benefits coverage utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, the contract provisions that include pharmacy benefits administration with the board must include the following terms:"

Section 1.1.a (page 1, lines 11-14)

Proposed language:

"The insurer shall provide the board with a copy of the insurer's current contract with the pharmacy benefit management company and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract"

Comments: We recommend clarifying the intent of this provision. If the intent is to review the contract agreement between the health insurer and the PBM, it is unlikely that either entity will agree to share their contract with the board. The insurer and the PBM will deem the contract proprietary.

If the intent of the provision is to review the pharmacy benefits contract agreement between the health insurer and/or PBM and the plan sponsor (the board) then the language could be modified to address this requirement directly.

Revised language recommendation: "The entity contracted for pharmacy benefits insurance coverage shall provide the board with a copy of the contract between the insurer and the plan sponsor, and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract"

Section 1.1.b (page 1, lines 15-18)

Proposed language:

"The health insurer or pharmacy benefit manager shall provide with each invoice statement and for each annual audit a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board"

Comments: We recommend receiving claims from the prescription drug provider on a monthly basis, consistent with current practice. This allows for all claims to be finalized before they are submitted for Data Warehousing. It also allows for appropriate comparison and reconciliation of the invoices to the paid pharmacy claims.

Revised language recommendation: "The health insurer or pharmacy benefit manager shall provide monthly and for each annual audit a complete set of electronic prescription

coverage claims data reflecting all submitted claims, including information fields identified by the board"

Section 1.1.c (page 1, lines 19-22)

Proposed language:

"The health insurer shall provide the board a list of all programs that will be implemented, including prior authorization programs, step therapy programs, quality limit programs, and mandatory generic programs. The list must include the drugs in each program and the specifics about each drug."

Comments: We recommend changing "quality limits" to "quantity limits" (likely an auto-correct).

We recommended clarifying what information is being requested for "the specifics about each drug". It would be helpful to clarify if the intent is to request the rationale for including each drug in the program, the anticipated disruption to members, expected cost avoidance, and/or details about each drug such as NDC Number, Drug Strength, Drug Indication, etc.

Revised language recommendation: "The health insurer shall provide the board a list of all programs that will be implemented, including but not limited to: prior authorization programs, step therapy programs, quantity limit programs, and mandatory generic programs. The list must include the drugs in each program, the cost of the program, the anticipated member disruption, process for override (if applicable), anticipated cost savings (or cost avoidance), performance guarantees (if applicable), and anticipated clinical outcomes."

Section 1.1.d (1) (page 2, lines 1-4)

Proposed language:

"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"

Comments: No comments, we agree with the provision as written.

Section 1.1.d (2) (page 2, lines 5-12)

Proposed language:

"The board may conduct annual audits to verify the pharmacy benefit manager is satisfying the terms of its contract with the health insurer; assess the costs resulting from the health insurer's contract with the pharmacy benefit manager and make recommendations as to amendments in that contract which would decrease costs; and

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assess the programs being implemented and make recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment."

Comments: We recommend clarifying if the intent is to audit the terms between the health insurer and the PBM or to audit the terms between the pharmacy benefits insurer and the plan sponsor.

Assessments of the clinical and/or utilization management programs should happen annually as part of the review process with the PBM. An audit of the terms of the contract may only result in the affirmation that a program is in place but might not lead to recommendations as to the outcomes of the program related to clinical outcomes or avoided cost.

Revised language recommendation: "The board may conduct annual audits to verify the pharmacy benefit provider is satisfying the terms of its contract with the plan sponsor; assess the costs resulting from the pharmacy benefit contract with the plan sponsor and make recommendations as to amendments in that contract which would decrease costs. The board requires, at minimum, annual review of the operational, clinical, and financial outcomes of the programs implemented and recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment."

Section 2 (page 2, lines 13-16)

Proposed language:

"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."

Comments: No comments, we agree with the provision as written.

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Finding the Formula for Drug Savings

The Role of Pharmacy Benefit Managers in the Health Care System

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What Is a PBM?

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What Is a PBM?

- A pharmacy benefits manager (PBM) is a health care company that contracts with insurers, employers, and government programs to administer the prescription drug portion of the health care benefit
- PBMs work with insurers and employers to perform a variety of services to ensure high-quality, cost efficient delivery of prescription drugs to consumers

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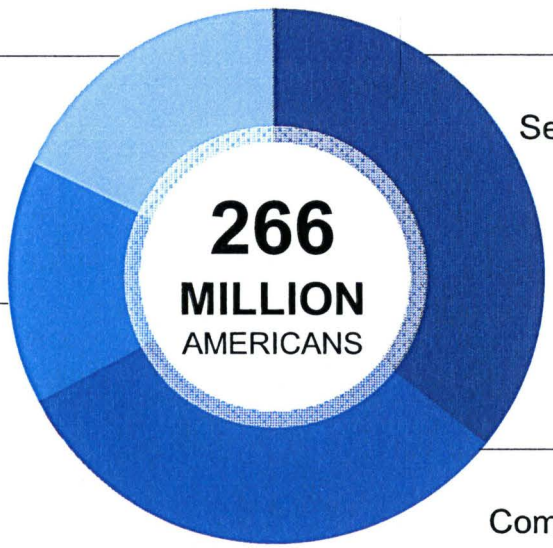
PBMs' National Footprint

More than **266 million Americans** receive pharmacy benefits provided through PBMs



18.0%
Medicaid*

35.7%
Self-Insured Employers

14.7%
Medicare Part D

31.6%
Commercial Health Plans

*Excludes Medicare-Medicaid Dual Eligibles where drugs are covered by Medicare Part D.
Source: Visante estimates prepared for PCMA, 2016.

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The Value of PBMs

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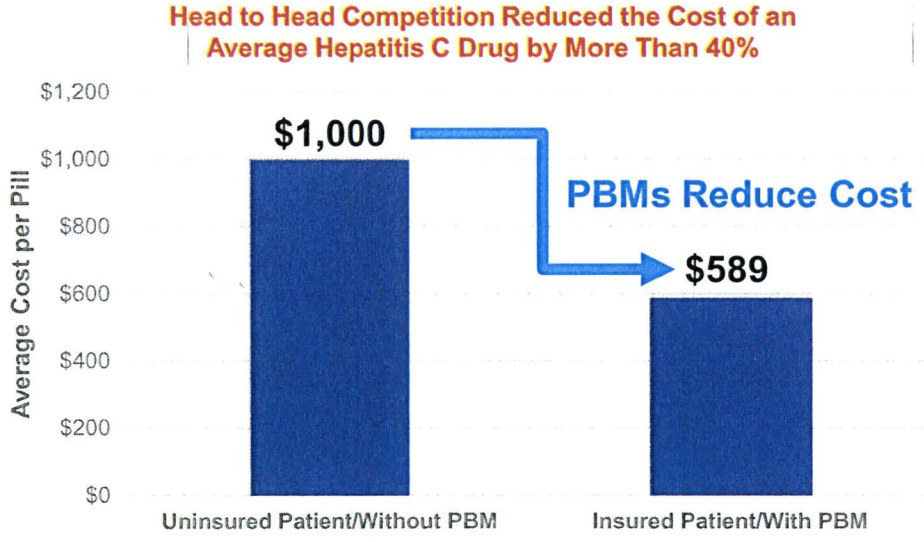
The Value of PBMs

PBMs save plan sponsors and consumers an average **35%** compared to expenditures made without pharmacy benefit management



Source: Visante, prepared for PCMA. February 2016.

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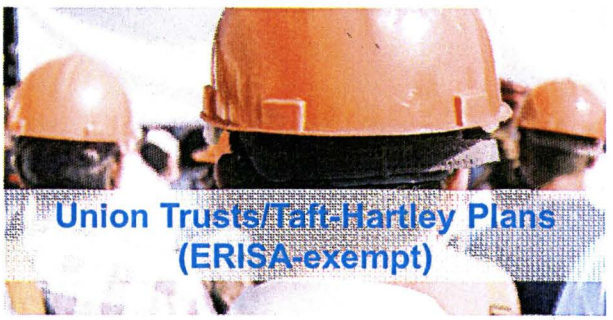
Who Are PBM Clients?



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Pharmacy Benefit Management Services

Claims Processing

Price, Discount and Rebate Negotiations with Pharmaceutical Manufacturers and Drugstores

Formulary Management

Pharmacy Networks

Mail-service Pharmacy

Specialty Pharmacy

Drug Utilization Review

Disease Management and Adherence Initiatives

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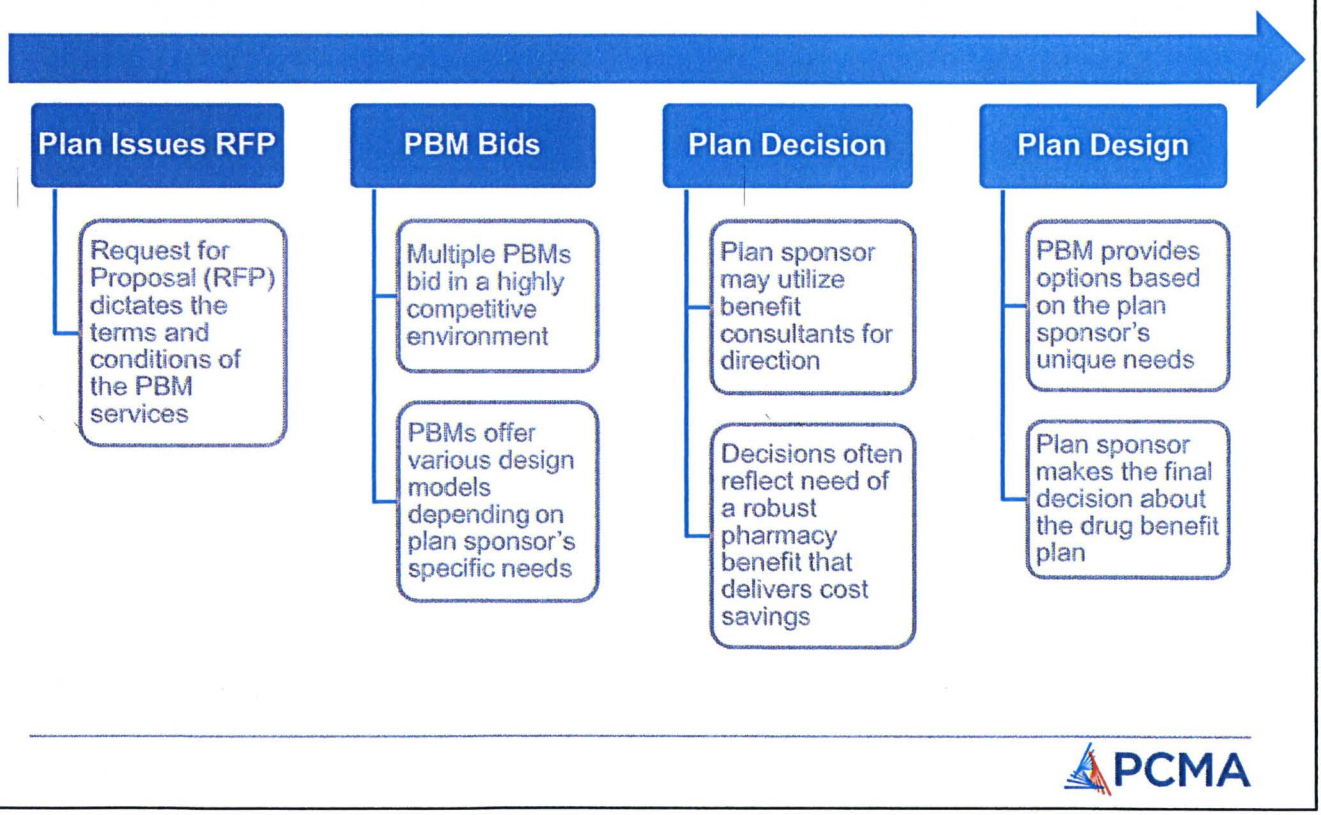
The Plan Sponsor RFP Process



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A Plan Sponsor Is the PBM's Client

- The plan sponsor always has the final say when creating a drug benefit plan
- There is no one-size-fits-all model because each plan sponsor has unique needs

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Prescription Drug Delivery & Financing

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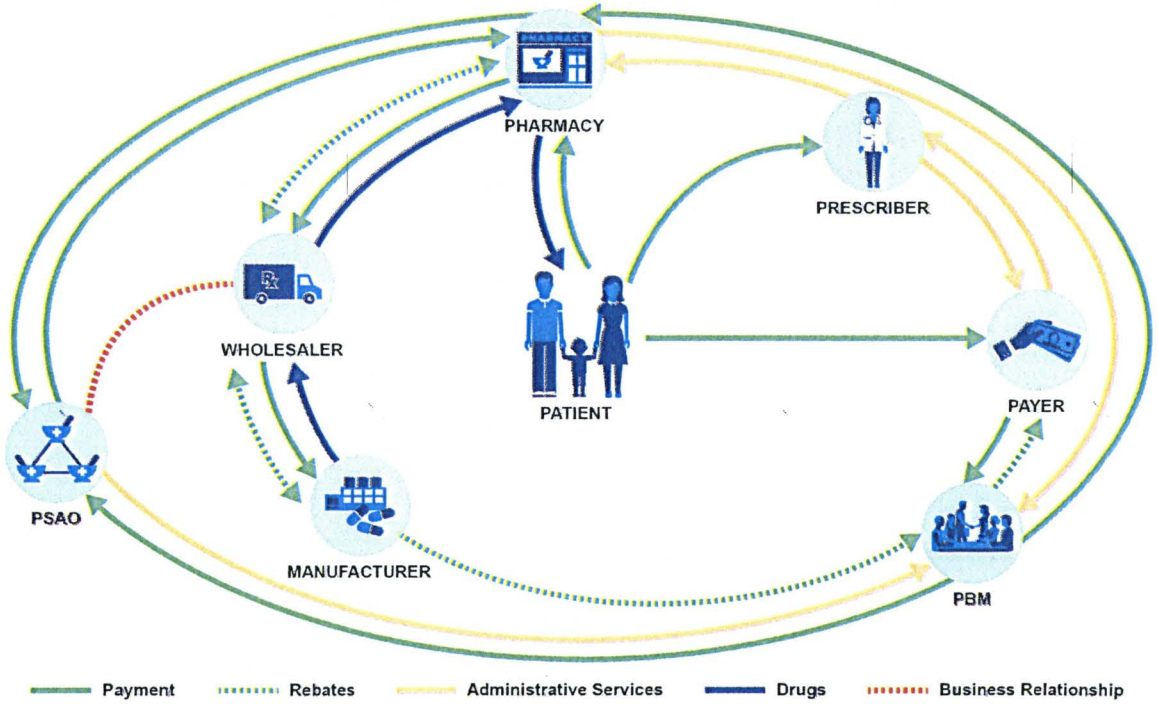
Flow of Goods, Transactions & Services



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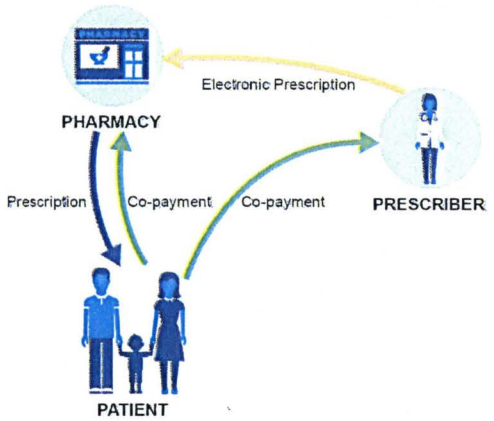
Patient-Prescriber-Pharmacy Interactions



Payment Rebates Administrative Services Drugs Business Relationship

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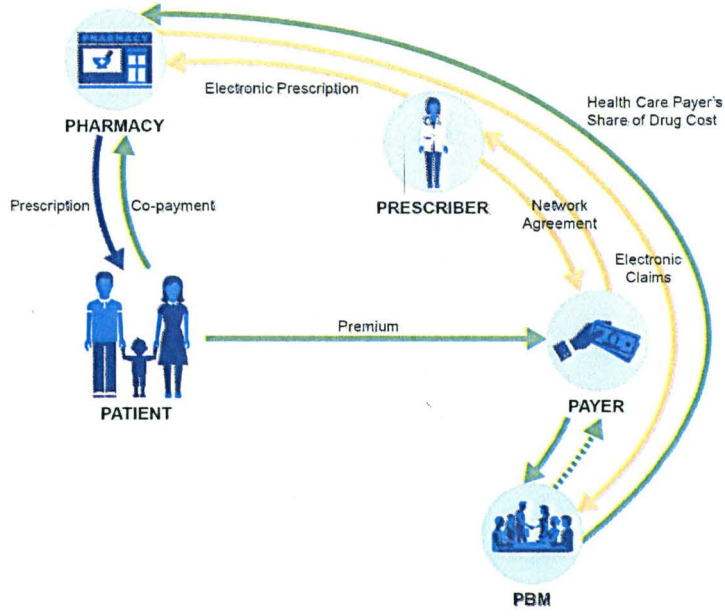
Prescription Drug Coverage



Payment Rebates Administrative Services Drugs Business Relationship

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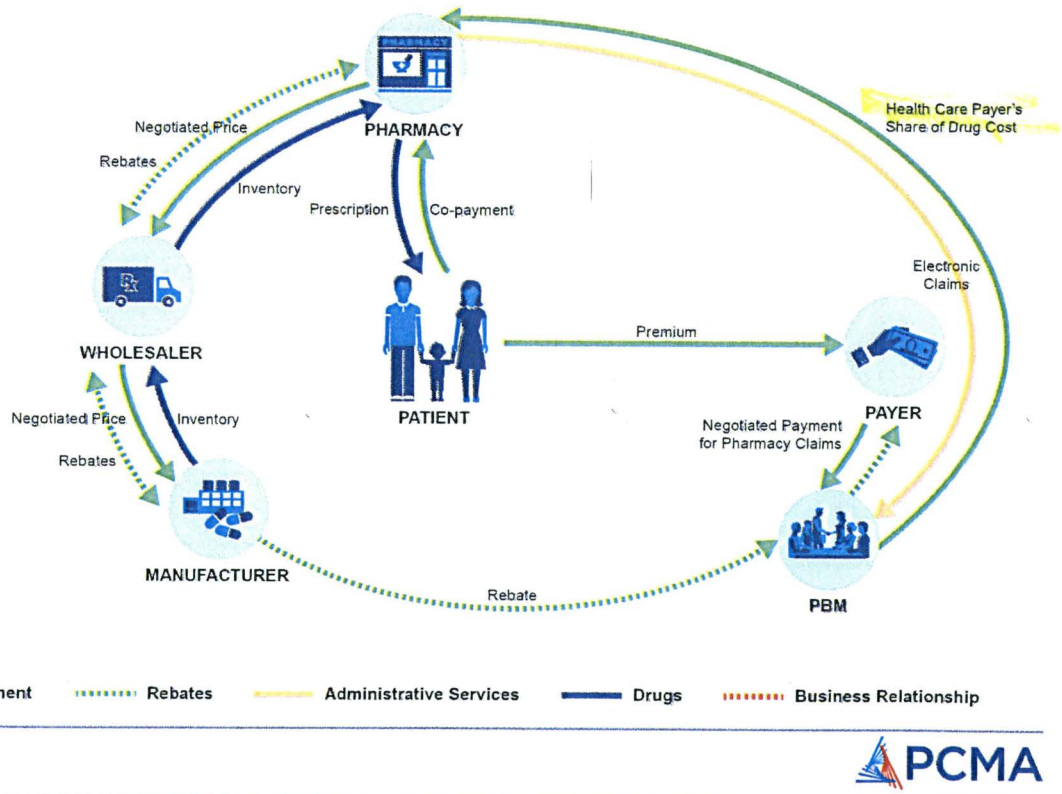
Drug Delivery and Reimbursement



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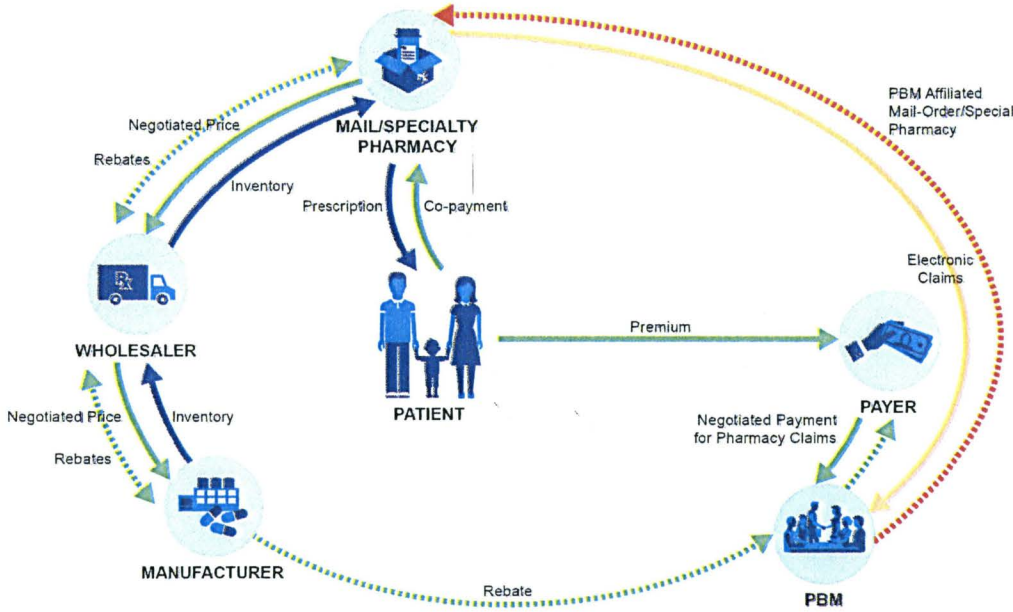
Home Delivery/Specialty Pharmacy



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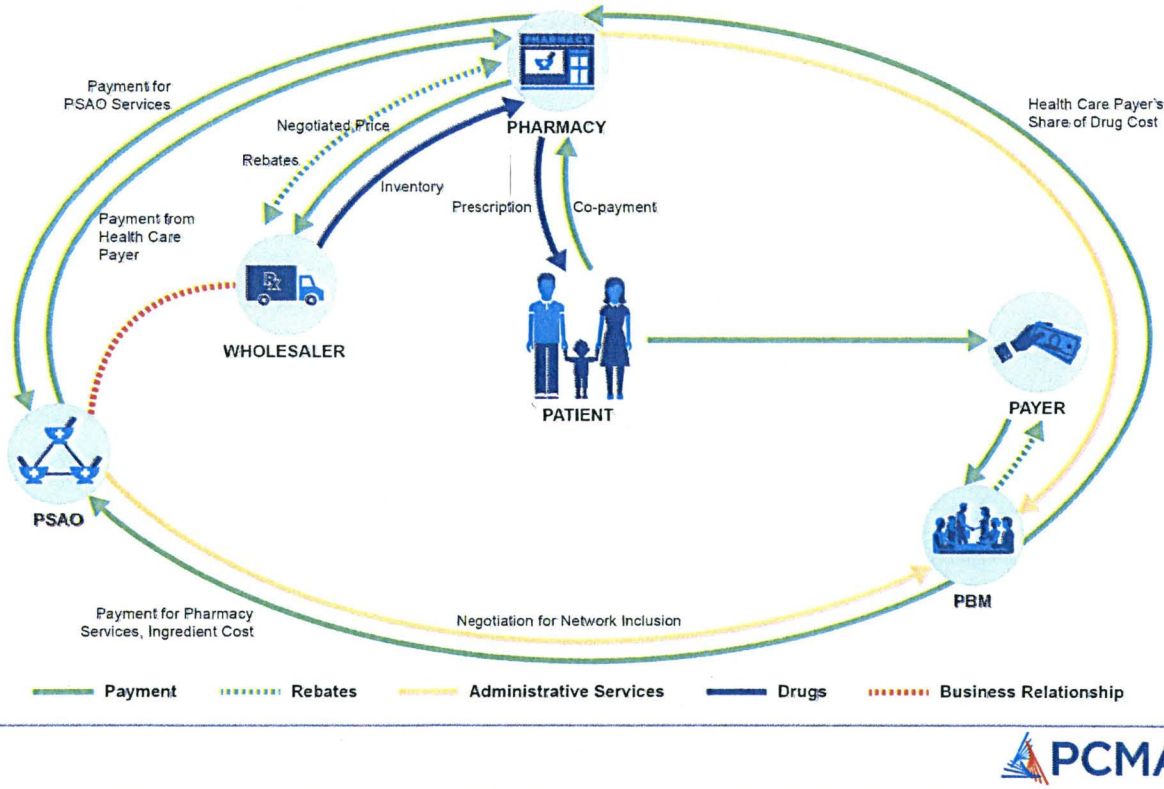
PSAOs

Pharmacy Services Administrative Organizations



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PBM Tools

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Tackling High Drug Costs

- **Health plans and PBMs do not have any control over the price the manufacturer sets for a drug** — but PBMs have some tools to drive down drug costs
- Patient cost-sharing often represents only a small fraction of the total cost of the drug
- Brand drug manufacturers establish prices within a monopoly established by federal patent law
- Until other drugs are approved for the same disease or condition, manufacturers have little incentive to reduce their prices

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PBM Tools

PBMs offer a set of core services to clients designed to contain drug expenditures. Key tools include:

Claims Administration

Pharmacy Network Management

Negotiation and administration of product discounts, including manufactures rebates

Mail-service Pharmacy

Specialty Pharmacy Services

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What Is a Mail-service Pharmacy?

- Many PBMs operate mail-service pharmacies, which send patients' prescription drugs directly to their home
- Health plans and employers frequently choose to incentivize their members and employees with the option of lower co-payments on maintenance medications for chronic conditions

A patient will go to her local drugstore for a new prescription

The patient will fill several 30-day prescriptions at the local drugstore

Once stabilized, the patient will use home delivery for maintenance drugs.

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Value of Mail-service Pharmacy

Home delivery promotes optimum consumer access to medications, especially for the elderly, the disabled, and the homebound

24/7 access to customer service representatives and pharmacists

Translation services

Specialty services for patients with disabilities

Cost-effectiveness

Monitoring for potential adverse drug events

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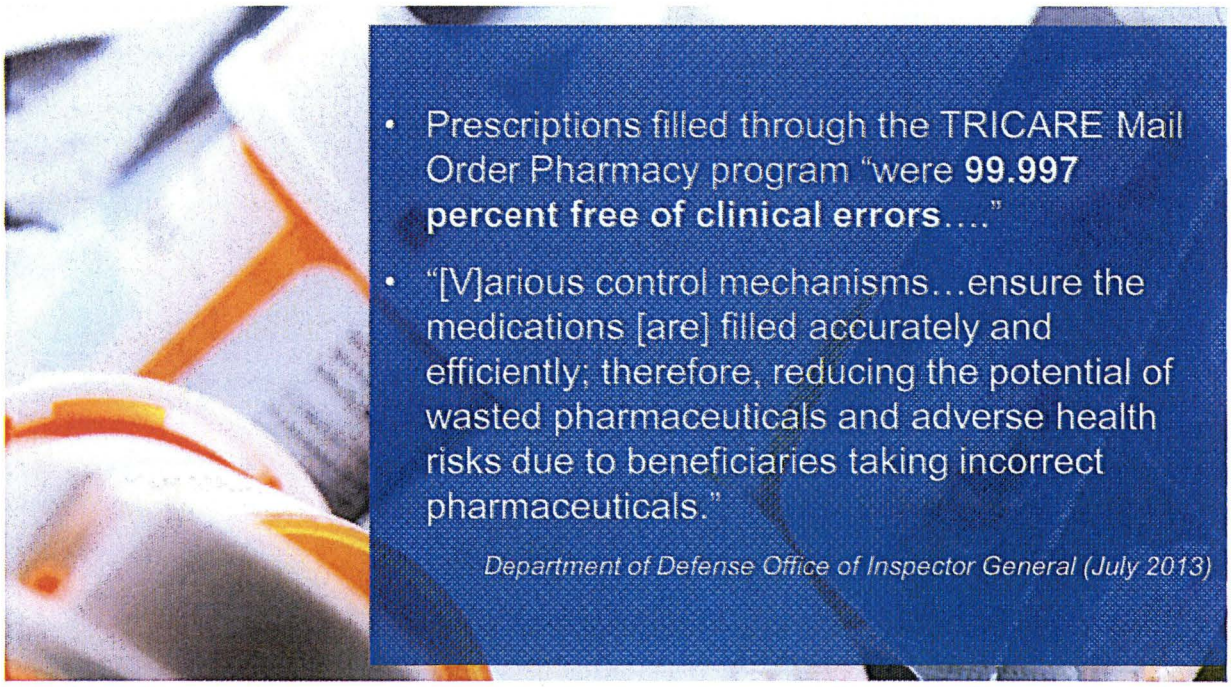
Value of Mail-service Pharmacy: Safety



- Prescriptions filled through the TRICARE Mail Order Pharmacy program "were **99.997 percent free of clinical errors**…."
- "[V]arious control mechanisms…ensure the medications [are] filled accurately and efficiently; therefore, reducing the potential of wasted pharmaceuticals and adverse health risks due to beneficiaries taking incorrect pharmaceuticals."

Department of Defense Office of Inspector General (July 2013)

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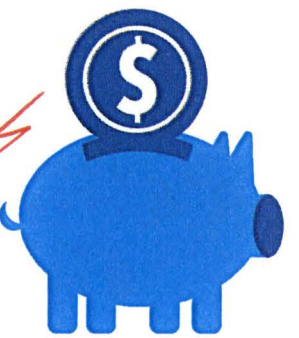
Value of Mail-service Pharmacy: Savings

- Mail-service pharmacies will yield a 10-year savings (2015–2024) of **$59.6 billion** for consumers, employers, and other payers
- CMS found that costs at mail-service pharmacies are **16% less** than retail pharmacies in Medicare Part D

$59.6
BILLION
SAVINGS



Sources: Visante, prepared for PCMA. September 2014.
Centers for Medicare and Medicaid Services, "Part D Claims Analysis: Negotiated Pricing Between General Mail Order and Retail Pharmacies." December 2013.

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What Is a Specialty Pharmacy?

- Specialty pharmacies specialize in the unique clinical, storage, and shipping requirements that some oral, injectable, inhalable, and infusible products require
- Retail and manufacturer-affiliated pharmacies are not typically equipped to manage the full range of products and services that PBMs and payers require for the distribution and management of specialty drugs (e.g., treatments for hepatitis C, multiple sclerosis, cancer, etc.)

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Growth of Specialty Drugs

In 2020, **9 of the 10** best-selling drugs by revenue will be specialty drugs, compared with 3 out of 10 in 2010, and 7 out of 10 in 2014

2010 2014 2020

Source: Drug Channels, July 28, 2015. "Pharma's Bright Future: Meet the Top 10 Drugs of 2020."

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Growth of Specialty Drugs

By 2018, projections show that specialty drugs will account for **50 percent** of all drug costs

Forecasted PMPY Net Drug Spend Across Pharmacy and Medical Benefit for Commercial Plan Sponsors

Source: Artemetrx, "An Evaluation of Specialty Drug Pricing Under the Pharmacy and Medical Benefit," March 2014

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Value of Specialty Pharmacy

Specialty pharmacy professionals
play a key role in patient care by providing:

24/7 access to pharmacists and clinicians specially trained in the patient's disease and clinical applications of the specialty drug

Physician consultations to address side effects, adverse reactions, and non-compliance

Patient care management services incorporating multiple safeguards to ensure patient safety

Data analytics to drive better patient outcomes

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Cost-effective Pharmacy Networks

- PBMs require network pharmacies to compete on service, price, convenience, and quality
- Three types of retail pharmacy networks include:
  - **Open Pharmacy Networks:** A plan's enrollees can use their prescription drug benefits at all network pharmacies for the same copay/cost sharing
  - **Preferred Pharmacy Networks:** Preferred pharmacies offer plans better discounts than the non-preferred drugstores, where enrollees benefit from lower copays/cost sharing
  - **Limited Pharmacy Networks:** Plan sponsors create a network limited to drugstores that offer deep discounts, which can lower costs by up to 10%. Plan enrollees have the same copay at all pharmacies in the network

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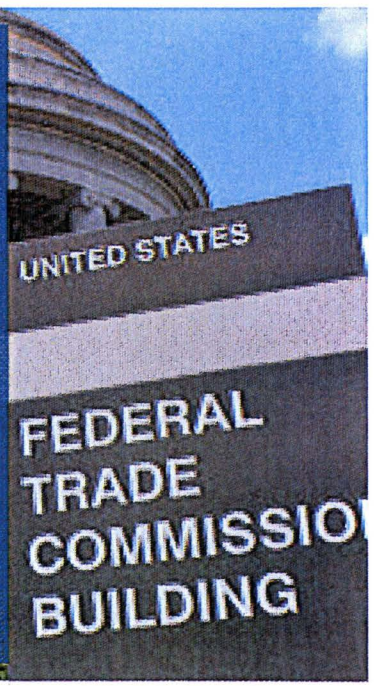
Value of Pharmacy Networks

"[R]estrictions on competition may result in insurance companies paying **higher fees to providers**, which generally lead to **higher premiums**, and may **increase the number of people without coverage**. Both economic theory and empirical evidence suggest that any willing provider and [freedom of choice] provisions are likely to have these negative effects."

Federal Trade Commission, 2014



Source: Federal Trade Commission Letter to the Centers for Medicare and Medicaid Services, Department of Health and Human Services (March 7, 2014).

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Prescription Drug Pricing & Reimbursement

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Generic Drug Reimbursement

- A maximum allowable cost (MAC) list specifies the maximum amount a PBM will reimburse a pharmacy for a particular generic drug
- Every manufacturer has its own price for a particular generic drug and these prices can differ extensively by manufacturer
- MAC lists standardize the reimbursement amount for identical products from various manufacturers, regardless of each manufacturer's price

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Generic Drug Reimbursement

- PBMs develop and maintain their own confidential MAC lists, based on proprietary methodologies that include a number of factors, such as survey of existing wholesale prices in the marketplace
- MAC lists help PBMs fairly compensate pharmacies while providing cost-effective drug benefits to their health plan and employer clients

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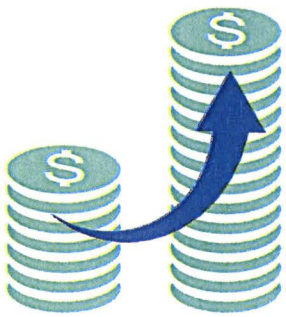
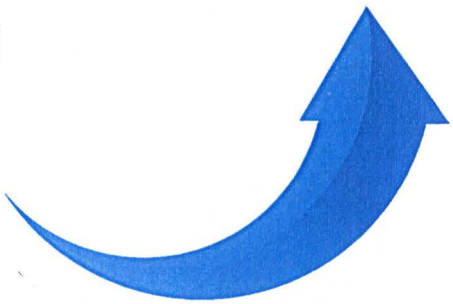
Value of MAC Lists

Recent research* has shown that
restrictions on MAC lists could:



Increase costs by
31% to 56% for affected
generic prescriptions.



Increase expenditures
nationally by up to
$5.5 billion annually.

Source: Visante, prepared for PCMA. January 2015.

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Conclusion

- Manufacturers are increasing drug prices for both brands and generics
- PBMs play a unique and central role in **driving adherence**, **holding down costs**, and **increasing quality**
- PBM tools **deliver savings** for plan sponsors and consumers, underscoring the success of the competitive marketplace

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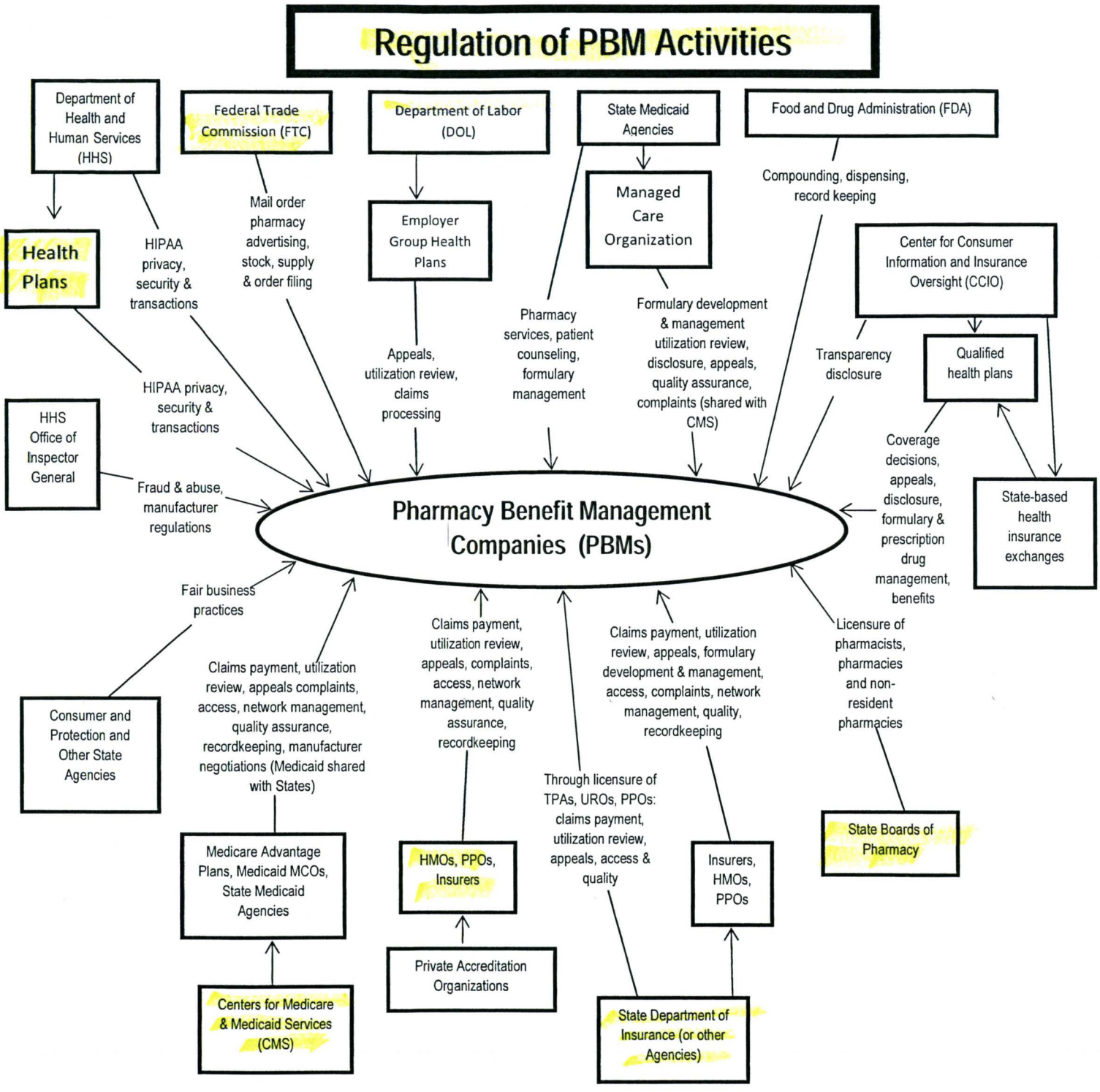
Regulation of PBM Activities
Department of Health and Human Services (HHS)
Federal Trade Commission (FTC)
Department of Labor (DOL)
State Medicaid Agencies
Food and Drug Administration (FDA)
Health Plans
HIPAA privacy, security & transactions
Mail order pharmacy advertising, stock, supply & order filing
Employer Group Health Plans
Managed Care Organization
Compounding, dispensing, record keeping
Center for Consumer Information and Insurance Oversight (CCIO)
HIPAA privacy, security & transactions
Appeals, utilization review, claims processing
Pharmacy services, patient counseling, formulary management
Formulary development & management utilization review, disclosure, appeals, quality assurance, complaints (shared with CMS)
Transparency disclosure
Qualified health plans
HHS Office of Inspector General
Fraud & abuse, manufacturer regulations
Pharmacy Benefit Management Companies (PBMs)
Coverage decisions, appeals, disclosure, formulary & prescription drug management, benefits
State-based health insurance exchanges
Fair business practices
Claims payment, utilization review, appeals complaints, access, network management, quality assurance, recordkeeping, manufacturer negotiations (Medicaid shared with States)
Claims payment, utilization review, appeals, complaints, access, network management, quality assurance, recordkeeping
Claims payment, utilization review, appeals, formulary development & management, access, complaints, network management, quality, recordkeeping
Licensure of pharmacists, pharmacies and non-resident pharmacies
Consumer and Protection and Other State Agencies
Medicare Advantage Plans, Medicaid MCOs, State Medicaid Agencies
HMOs, PPOs, Insurers
Through licensure of TPAs, UROs, PPOs: claims payment, utilization review, appeals, access & quality
Insurers, HMOs, PPOs
State Boards of Pharmacy
Private Accreditation Organizations
Centers for Medicare & Medicaid Services (CMS)
State Department of Insurance (or other Agencies)

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3/7
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NDLA, S HMS - Johnson, Marne

[redacted]
Sent: Lee, Judy E.
Tuesday, March 07, 2017 12:58 PM
To: NDLA, S HMS - Johnson, Marne; NDLA, Intern 02 - Arendt, Ian
Subject: FW: PBM Audit Bill HB 1403

Importance: High

Copies, please

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Mike Schwab [mailto:[redacted]
Sent: Tuesday, March 7, 2017 11:31 AM
To: Lee, Judy E. <jlee@nd.gov>
Cc: Anderson, Jr., Howard C. <hcanderson@nd.gov>; Clemens, David <dclemens@nd.gov>; Heckaman, Joan M. <jheckaman@nd.gov>; Larsen, Oley L. <olarsen@nd.gov>; Kreun, Curt E. <ckreun@nd.gov>; Piepkorn, Merrill <mpiepkorn@nd.gov>
Subject: PBM Audit Bill HB 1403
[redacted]**tance:** High

Hello Madam Chair and members of the Human Service Committee,

My apologies but I could not make it to the hearing this morning related to HB 1403 – Ability to audit the PBM under NDPERS

The ND Pharmacists Association supports HB 1403 and hope members of this committee will also feel the same way. We feel any time there is an opportunity to bring about more transparency in the Pharmacy Benefit Managers (PBMs) industry it is a good thing! Currently, if I understand the process correctly, any NDPERS audit of the PBM (Express Scripts in this case) is currently done by the Health Plan (Sanford in this case) without an option for NDPERS to audit the PBM if they wanted to do so using an independent unbiased entity.

Given the lack of transparency in the PBM market and significant dollars spent on prescription drugs under NDPERS, it makes sense and should be a "right" as well as a "standard of practice" for all employers frankly.

Please let me know if you have any questions. Thank you for your time and attention.
Respectfully,

[redacted]
Mike Schwab
Executive Vice President

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ND Pharmacists Association
1641 Capitol Way
Bismarck, ND 58501
Phone: 701-258-4968
Fax: 701-258-9312

www.nodakpharmacy.net

HB1403
#1
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NDLA, Intern 02 - Arendt, Ian

From: Lee, Judy E.
Sent: Monday, March 20, 2017 8:35 AM
To: -Grp-NDLA Senate Human Services; NDLA, S HMS - Johnson, Marne; NDLA, Intern 02 - Arendt, Ian
Subject: FW: (Rep. Kasper) - Amendments to HB No. 1403 - 17.0720.02001

Copies, please

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Kasper, Jim M.
Sent: Monday, March 20, 2017 8:30 AM
To: Lee, Judy E. <jlee@nd.gov>; Kasper, Jim M. <jkasper@nd.gov>; Collins, J. Sparb <scollins@nd.gov>
Subject: FW: (Rep. Kasper) - Amendments to HB No. 1403 - 17.0720.02001

Hi Senator Lee:

Please review Linda's comments and suggestions for an amendment.

These are the amendments I support. I do not support the amendment Sparb will provide you today unless it is this amendment.

Thank you.

Rep. Jim Kasper

Rep. Jim Kasper
Chairman, Gov't & Veterans Affairs Committee
ND House of Representatives
District 46
1128 Westrac Drive
Fargo, ND 58103
Office Phone: 701-232-6250
Cell Phone: 701-799-9000
State Email: jkasper@nd.gov
Bus. Email: jmkasper@amg-nd.com

From: LINDA CAHN [mailto:lindacahn@mac.com]
Sent: Monday, March 20, 2017 8:15 AM
To: Kasper, Jim M. <jkasper@nd.gov>; Collins, J. Sparb <scollins@nd.gov>; Clark, Jennifer S. <jclark@nd.gov>

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#1
3/21

Cc: mschwab@nodakpharmacy.net
Subject: Re: (Rep. Kasper) - Amendments to HB No. 1403 - 17.0720.02001

Assemblyman Kasper, Sparb, and others on the North Dakota Team:

I don't know what happened to the text of this Amendment since the previous version that I reviewed, but it is now scrambled so that it doesn't really make sense.

The basic problem is that the first paragraph of the Amendment now appears to be addressing the RFP process - not the audit process - and then most (although not all) of the remaining paragraphs of the Amendment appear to be addressing audit issues. This makes the statute almost nonsensical.

To help you see the problem, I have taken all the Amendment changes, and rewritten the statute to incorporate all of the Amendment changes. Here's how the Statute now reads as a result (with my interlineated comments in purple font):

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 benefit 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 with the following terms:

The newly revised opening paragraph of your Amendment is now designed to impact *your next RFP process*, rather than your *next audit*. This creates a major problem: the Amendment now makes no sense, b/c the next changes that result from your Amendment are almost all written to address audit issues, not RFP issues. The next paragraphs now read as follows:

a) The insurer shall provide the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefit management company and if the contract is revised or a new contract is entered within thirty days of the change the insurer shall provide the board with the revision or new contract.

The above language is "audit language" - designed to state what information must be provided to the auditor.

b) The health insurer or pharmacy benefit manager monthly shall provide and for each annual audit a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.

The above language addresses both matters - a "standard" for preference for RFP bids, and what must be provided in an audit

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c) The health insurer shall provide the board a list of all programs that will be implemented or modified, including prior authorization programs, step therapy programs, quantity limit programs, and mandatory generic programs. The list must include the drugs in each program, the cost of the program, the anticipated member disruption, a description of any process for override, anticipated cost savings or avoidance, a description of any performance guarantees, and anticipated clinical outcomes.

The above, as written, appears to be RFP language, not audit language since the verb is "will be implemented or modified". But if that language was changed to read "are being implemented or will be modified" it would read more like audit language.

d)

1) The board shall retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor.

2) The board shall conduct annual audits to verify the pharmacy benefit manager is satisfying the terms of its contract with the health insurer as it pertains to the plan sponsor. The board's auditor also annually shall provide financial and clinical analyses to the board and make recommendations for proposed changes to the prescription drug benefits coverage, including modifications of the copayment, coinsurance or deductible, drugs covered and not covered, and programs implemented under subdivision c of subsection 1, to decrease cost or improve plan beneficiaries health care treatment.

The above language is obviously audit language.

2. Information provided to the board under the contract provisions require 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.

Bottom line: Given the late date and your own processes, I'm not sure what to do to "clean this up", but here are my suggestions:

Rather than trying to interlineate changes to your existing statute, why not state that you are deleting lines 9 - 23 of page 1, and lines 1-18 of page 2, and then write what you want to write.

I've taken the above language, stuck to it as closely as I could, but now rewritten it again to accomplish two objectives - ensuring a better RFP process and a better audit process. I've done so by breaking out the two matters into separate sections:

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 benefit 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 with the following terms:

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a) A contract that allows the board to review the actual terms of the contract controlling prescription coverage

b) The extent to which the contract provides the board with transparency to see:

i. all claims data on a monthly basis

ii. information related to the programs that are being implemented, including without limitation, any prior authorization, step therapy, mandatory generic or quantity limit program

c) The extent to which the contract allows the board, in its discretion, to customize:

- the benefit plan design, including copayments/coinsurance/deductibles and out-of-pocket limits
- the drugs that are covered (and not covered)
- the formulary
- the programs identified in subsection 1(b)(ii) above

d) the extent to which the contract provides audit rights to the board

e) the total costs of the contract, which shall be evaluated as follows:

- for each year of the contract and for the full term of the contract
- if the request for bids results in the submission of bids for fully-insured, self-insured or any hybrid arrangement, comparing the actual costs that will result from a fully-insured contract with the projected costs of either form of alternative contract, and giving preference to the lowest of all such costs

2. In connection with any audit related to the services of a pharmacy benefit manager, either contracted directly with a pharmacy benefit manager or indirectly through the health insurer, the board shall ensure that the following take place:

a) If the board has contracted with an insurer (and not directly with the pharmacy benefit manager), the insurer shall provide the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefit manager, and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract.

b) The health insurer or pharmacy benefit manager shall provide a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.

c) The health insurer shall provide the board with a list of all programs that have been implemented or modified during the audit period, including without limitation: prior authorization programs, step therapy programs, quantity limit programs, and mandatory generic programs. In connection with

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each listed program, the board shall direct the auditor to determine and report to the board about the following matters: the cost of each program, the cost savings or avoidance of each program, the member disruption resulting from each program, the process for and number of overrides or approvals/disapprovals in each program, and the clinical outcomes of each program.

d)

1) The board shall retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor.

2) The board shall conduct annual audits to verify the pharmacy benefit manager is satisfying the terms of its contract with the health insurer or with the board. The board's auditor also annually shall provide financial and clinical analyses to the board of, and make recommendations for proposed changes to, the prescription drug benefits coverage program to decrease costs and/or improve plan beneficiaries' health care treatment. Such recommendations shall include without limitation potential modifications of: the copayment/coinsurance/ deductibles/out of pocket limits; drugs that are covered (and not covered); and programs that are implemented under subsection 1(b)(ii).

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. This statute shall take effect immediately, other than subsection 2(a), which shall take effect when the current contract providing prescription coverage is renewed or replaced with a new contract.

On Mar 19, 2017, at 2:16 PM, Kasper, Jim M. <jkasper@nd.gov> wrote:

Mike and Linda:

here is the latest amendment to HB 1403 that Jennifer at Legislative council did.

Please review and advise if ok.

Need feedback as soon as possible as Sen. Judy Lee is anxious to get this bill out of her committee Monday.

JIm
Rep. Jim Kasper
Chairman, Gov't & Veterans Affairs Comm.
ND House of Representatives
District 46
1128 Westrac Drive

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Fargo, ND 58103
Office Phone: 701-232-6250
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State Email: jkasper@nd.gov
Bus. Email: jmkasper@amg-nd.com

From: -Adm-Legislative Council
Sent: Friday, March 17, 2017 4:13 PM
To: Kasper, Jim M.
Cc: Clark, Jennifer S.; jmkasper@amg-nd.com; lindacahn@mac.com
Subject: (Rep. Kasper) - Amendments to HB No. 1403 - 17.0720.02001

<17.0720.02001a.pdf>

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HB 1403 as amended:

1. Establishes as a preference criteria (1,2,3,4,5, 6, 7 & 8)
2. Establishes the audit process for PBM's (9 & 10)
3. Establishes the confidentiality of the process (11)
4. Authorizes the Board to pick an Auditor (12)

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HB 1403 Proposed Amendments

	Amendment	Purpose
1	Page 1, line 9, after the second "coverage" insert "contract received in response to a request for bids under section 54-52.1-04" Page 1, line 10, replace the second "the" with "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 a" Page 1, line 11, remove "board must include the"	Responds to the suggestion from the PERS Board. They are proposing that this become a "preference criteria" in selecting a vendor or vendors for the health plan. As presently worded, it is our interpretation that if a vendor would not agree to these provisions, we would be unable to select them regardless of other variables. The implications of this could be: 1. That if we only had one vendor bid and they did not agree to these terms we may not be able to award the plan in a timely manner. 2. That we get more than one bid, but the one willing to accept these terms could be significantly higher priced and we would be required to accept them. If this is a preference criterion, the board could consider the entire scope of the responses. Also, it would be helpful if the board was provided discretion to negotiate these provisions and use them as a guide. For example, if we were able to get a vendor to agree to substantially most of these requirements, or the intent of these requirements, but in a different form, it would be helpful to allow the discretion to accept that offer. As preference criteria, the above could be accommodated
2	Page 1, line 12, remove "The insurer shall" Page 1, line 12, replace "provide" with "Provides"	Edit and part of the contract preference criteria
3	Page 1, line 12, after "board" insert "or the boards' auditor"	Adds the boards auditor as part of the contract preference criterial
4	Page 1, line 13, after "company" insert ", that is controlling of the prescription drug coverage offered as part of	Clarification

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	Amendment	Purpose
	the health insurance benefits coverage,"	
5	Page 1, line 16, remove "The health insurer or pharmacy benefit manager shall" Page 1, line 16, replace "provide" with "Provides the board with monthly claims data and information on all programs being implemented or modified, including, prior authorization, step therapy, mandatory generic or quantity limit program." Page 1, line 16, remove "with each invoice"	Establishes criteria. Rewording and changes "each invoice "to "monthly"
6	Page 1, remove lines 17 through 19	17 statement and for each annual audit a complete set of electronic prescription 18 coverage claims data reflecting all submitted claims, including information fields 19 identified by the board. While removed here it is added in 9
7	Page 1, line 20, remove "The health insurer shall" Page 1, line 20, replace "provide" with "Describes the extent to which the board may customize: the benefit plan design, including copayments, coinsurance, deductibles and out of	Establishes the criteria

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	Amendment	Purpose
	pocket limits; the drugs that are covered, the formulary, and the member programs implemented" Page 1, line 20, remove "the board a list of all programs that will be"	
8	Page 1, remove lines 21 through 23	21 implemented or modified, including prior authorization programs, step therapy 22 programs, quality limit programs, and mandatory generic programs. The list must 23 include the drugs in each program and the specifics about each drug. While moved here it is added in 9
9	Page 2, line 1, remove "The board may retain an auditor of the board's choice which is not a" Page 2, line 5 replace "(2)" with "2." Page 2, line 5, after "to" insert "the extent permitted pursuant to contract terms agreed to under subsection1, such audits to include: a. Review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board. b. Review of a list of all programs that have been implemented or modified during the audit period pursuant to subsection1, and in connection with each program the	This is added in 12 Creates a new section 2 Discussing the audit

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	Amendment	Purpose
	auditor shall report on: the cost, the cost savings or avoidance, member disruption, 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."	
10	Page 2, line 5, remove "verify the pharmacy benefit" Page 2, remove lines 6 through 12	manager is satisfying the terms of its contract with the health insurer; assess the costs resulting from the health insurer's contract with the pharmacy benefit manager and make recommendations as to amendments in that contract which would decrease costs; and assess the programs being implemented and make recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment. This language was slightly modified and added in 9
11	Page 2, line 13, replace "2." with "3."	Section 2 become section 3
12	" 4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor."	Adds this as section 4

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PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

Page 1, line 9, replace the second "the" with "a"

Page 1, line 9, after the second "coverage" insert "contract received in response to a request for bids under section 54-52.1-04"

Page 1, line 10, replace the second "the" with "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"

Page 1, line 11, remove "board must include the"

Page 1, line 12, remove "The insurer shall"

Page 1, line 12, replace "provide" with "Provides"

Page 1, line 12, after "board" insert "or the boards' auditor"

Page 1, line 13, after "company" insert ", that is controlling of the prescription drug coverage offered as part of the health insurance benefits coverage,"

Page 1, line 16, remove "The health insurer or pharmacy benefit manager shall"

Page 1, line 16, replace "provide" with "Provides the board with monthly claims data and information on all programs being implemented or modified, including, prior authorization, step therapy, mandatory generic or quantity limit program."

Page 1, line 16, remove "with each invoice"

Page 1, remove lines 17 through 19

Page 1, line 20, remove "The health insurer shall"

Page 1, line 20, replace "provide" with "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"

Page 1, line 20, remove "the board a list of all programs that will be"

Page 1, remove lines 21 through 23

Page 2, line 1 replace "(1)" with "Describes the audit rights of the board."

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Page 2, line 1, remove "The board may retain an auditor of the board's choice which is not a"

Page 2, remove lines 2 through 4

Page 2, line 5 replace "(2)" with "2."

Page 2, line 5, after "to" insert "the extent permitted pursuant to contract terms agreed to under subsection1, such audits to include:

a. Review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.
b. Review of a list of all programs that have been implemented or modified during the audit period pursuant to subsection1, and in connection with each program the auditor shall report on: the cost, the cost savings or avoidance, member disruption, 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."

Page 2, line 5, remove "verify the pharmacy benefit"

Page 2, remove lines 6 through 12

Page 2, line 13, replace "2." with "3."

Page 2, after line 16 insert

" 4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor."

Renumber accordingly

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PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

Page 1, line 9, replace the second "the" with "a"

Page 1, line 9, after the second "coverage" insert "contract received in response to a request for bids under section 54-52.1-04"

Page 1, line 10, replace the second "the" with "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"

Page 1, line 11, remove "board must include the"

Page 1, line 12, remove "The insurer shall"

Page 1, line 12, replace "provide" with "Provides"

Page 1, line 12, after "board" insert "or the boards' auditor"

Page 1, line 13, after "company" insert ", that is controlling of the prescription drug coverage offered as part of the health insurance benefits coverage,"

Page 1, line 16, remove "The health insurer or pharmacy benefit manager shall"

Page 1, line 16, replace "provide" with "Provides the board with monthly claims data and information on all programs being implemented or modified, including, prior authorization, step therapy, mandatory generic or quantity limit program."

Page 1, line 16, remove "with each invoice"

Page 1, remove lines 17 through 19

Page 1, line 20, remove "The health insurer shall"

Page 1, line 20, replace "provide" with "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"

Page 1, line 20, remove "the board a list of all programs that will be"

Page 1, remove lines 21 through 23

Page 2, line 1 replace "(1)" with "Describes the audit rights of the board."

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Page 2, line 1, remove "The board may retain an auditor of the board's choice which is not a"

Page 2, remove lines 2 through 4

Page 2, line 5 replace "(2)" with "2."

Page 2, line 5, after "to" insert "the extent permitted pursuant to contract terms agreed to under subsection1, such audits to include:

a. Review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.
b. Review of a list of all programs that have been implemented or modified during the audit period pursuant to subsection1, and in connection with each program the auditor shall report on: the cost, the cost savings or avoidance, member disruption, 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."

Page 2, line 5, remove "verify the pharmacy benefit"

Page 2, remove lines 6 through 12

Page 2, line 13, replace "2." with "3."

Page 2, after line 16 insert

" 4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor."

Renumber accordingly

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17.0720.02003

Sixty-fifth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1403

Introduced by

Representatives Kasper, Rick C. Becker, Boehning, Headland, Keiser, Louser, Nathe, D. Ruby

Senators Anderson, Bekkedahl, Casper, O. Larsen

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee health benefits transparency~~; and to provide an exemption~~.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

1. If the prescription drug coverage component of ~~the~~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, ~~the~~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 with the ~~board must include the~~ following terms:
   a. ~~The insurer shall provide~~Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefit management company, that is controlling of the prescription drug coverage offered as part of the health insurance benefits coverage, and if the contract is revised or a new contract is entered, within thirty days of the change the insurer shall provide the board with the revision or new contract.
   b. ~~The health insurer or pharmacy benefit manager shall provide with each invoice statement and for each annual audit a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields~~

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~~identified by the board.~~Provides the board with monthly claims data and information on all programs being implemented or modified, including, prior authorization, step therapy, mandatory generic or quantity limit program.

c. ~~The health insurer shall provide the board a list of all programs that will be implemented or modified, including prior authorization programs, step therapy programs, quality limit programs, and mandatory generic programs. The list must include the drugs in each program and the specifics about each drug.~~Describes the extent to which the board may customize: the benefit plan design, including copayments, coinsurance, deductibles, and out of pocket limits; the drug that are covered, the formulary, and the member programs implemented.

d. ~~(1) The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor.~~

~~(2) The board may conduct annual audits to verify the pharmacy benefit manager is satisfying the terms of its contract with the health insurer; assess the costs resulting from the health insurer's contract with the pharmacy benefit manager and make recommendations as to amendments in that contract which would decrease costs; and assess the programs being implemented and make recommendations as to improvements in those programs which would decrease cost or improve plan beneficiaries' health care treatment.~~Describes the audit rights of the board.

2. The board may conduct annual audits to the extent permitted pursuant to contract terms agreed to under subsection 1, such audits are to include:

a. Review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.

b. Review of a list of all programs that have been implemented or modified during the audit period pursuant to subsection 1, and in connection with each program the auditor shall report on: the cost, the cost savings or avoidance, member disruption, process for and number of overrides or approvals and disapprovals, and clinical outcomes.

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c. Recommendations for proposed changes to the prescription drug benefit programs to decrease costs and improve plan beneficiaries' health care treatment.

~~2.~~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.

~~**SECTION 2. EXEMPTION.** This Act is exempt from the jurisdiction of the employee benefits programs committee under section 54-35-02.4.~~

4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefit manager, a pharmaceutical manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor.

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Appendix A: Cases against Pharmacy Benefit Managers

Appendix A offers a summary of cases against pharmacy benefit managers ("PBMs"). This is not a complete list of all litigation against PBMs. The case summary focuses on cases claiming PBM deception, fraud, or antitrust violations.

Year	Case	Summary
2016	*In Re UnitedHealth Group PBM Litigation*, Case No. 16-cv-3352 (D.MN.)	Class action lawsuit against Optum Rx parent, UnitedHealth alleging Optum required network pharmacies to charge patients unauthorized and excessive amounts for prescription drugs. Optum then clawed back these excessive payments by forcing the pharmacies to pay the unauthorized or excessive charges to Optum after collecting them from the patients.
2016	*Prime Aid Pharmacy Corp., v. Express Scripts, Inc.*, Case No: 2:16-cv-02182 (E.D. Mo.)	Prime Aid Pharmacy files antitrust law suit against Express Scripts for fraudulent scheme and anticompetitive behavior between specialty pharmacies and the specialty pharmacies that Express Scripts owns and operates.
2016	*Express Scripts receives subpoena from U.S. Attorney's Office for the District of Massachusetts*	U.S. Attorney Office seeking information about Express Scripts relationship with drug makers, charitable foundations they own that and provide assistance to federal health care program beneficiaries and specialty pharmacies.
2016	*Express Scripts receives subpoena from the U.S. Attorney of New York*	U.S. Attorney's office seeking information about Express Scripts relationship with drug makers and prescription drug plan clients and payments schemes to and from both.
2016	*Richard Medoff v. CVS Caremark Corporation, et al.*, Case No: 1:09-cv-00554-JNL-PAS	A securities class action suit against CVS Caremark for False and Misleading Statements related to its merger and profitability related to substantial loss of business after CVS's 2007 merger with Caremark resulted in a 2016 settlement in the sum of **$48,000,000 million** to the class action plaintiffs.
2016	*Anthem v. Express Script, Inc.*, Case No. 16-cv-2048 (S.D.N.Y.)	Anthem has accused Express Scripts of breaching their management services agreement by charging inflated prices and refusing to renegotiate in good faith. Among the several additional claims, Anthem said Express Scripts did not properly comply with regulations set out by the Centers for Medicare & Medicaid Services regarding Medicare Part D claims. Anthem is seeking **$15 Billion in damages.**
2016	*Burnett v. Express*	Express Scripts Inc. and Anthem are accused in a

	Scripts, Inc., Case No. 1:16-cv-04948 (S.D.N.Y.)	proposed class action of breaching their ERISA fiduciary duties that caused the plan participants to overpay for drug benefits. Specifically, plaintiffs accuse Express Scripts charged "above competitive pricing levels" and Anthem allowed these prices as part of a 10-year contract deal with the pharmacy benefit manager. This case was brought by plans sponsored by Verizon Communications Inc., AmTrust Financial Services and LG&E and KU Energy LLC and their 26,000 combined participants.
2016	*Trone Health Services Inc et al. v. Express Scripts*, Case No.4:16-cv-01250-RLW (E.D. Mo.)	Trone Health Services Inc on behalf of all similarly situated pharmacies in the United State alleging Unfair Competition, breach of contract, breach of implied covenant of good faith and fair dealing, interference with economic advantage, violation of uniform trade secrets act and fraud for the practice of "slamming" to personally enrich Express Scripts. Slamming is the process of utilizing pharmacy information related to customers and customers' prescriptions to forcibly switch customers from Plaintiffs' retail pharmacies to Defendant's own mail-based pharmacies. Trial by jury date not set yet.
2015	*United States ex rel. DiMattia et al. v. Medco Health Solutions, Inc.*, No. 13-1285 (D. Del.).	The United States alleged that Medco (now part of Express Scripts) violated the False Claims Act. In particular, it was alleged that Medco solicited remuneration from AstraZeneca in exchange for identifying Nexium as the "sole and exclusive" proton pump inhibitor on certain of Medco's prescription drug lists. As a result of this deal, Medco received reduced prices on AstraZeneca drugs: Prilosec, Toprol XL and Plendil. Medco settled the case and **agreed to pay $7.9 million** to resolve the kickback allegations.
2015	*Kmart Co. v. Catamaran Co.*, No. 2015-L-008290 (Ill. Ct. Cl.)	Kmart alleges that Catamaran "improperly manipulated prescription reimbursements." In particular, Kmart alleges that Catamaran cut payments to Kmart pharmacies and failed to reimburse Kmart for almost 28,000 pricing appeals. As a result of these pricing appeals, Kmart has **suffered $38 million in damages**. This case is ongoing.
2015	*Albert's Pharmacy, Inc. et al v. Catamaran Corporation*, Civ. No. 3:15-cv-00290-UN2 (M.D. Pa.)	Fifty-five independent pharmacies sued Catamaran for illegal conduct. The parties allege that Catamaran inflated patient costs while simultaneously underpaying pharmacies. Specifically, the pharmacies argue that Catamaran set rates below cost, made pricing data inaccessible, did not update data, and

		provided no transparency on how drugs rebates are applied. As a result of Catamaran's practices, the pharmacies' business and continued delivery of patient care are at risk. This case is ongoing.
2015	*U.S. ex rel., et al. v. Novartis Pharmaceuticals Corp.*, No. 1:11-cv-08196 (S.D. N.Y.)	The United States sued Accredo (owned by Express Scripts) claiming that Accredo recommended the drug Exjade to Medicaid patients in exchange for kickbacks from Novartis Pharmaceuticals Corp., which markets the drug. **Accredo settled the matter paying $60 million to the federal government and various states.**
2015	*John Doe v. Medco Health Solutions Inc., et al.*, Case No. 1:11-cv-00684 (D. Del.)	A relator on behalf of the United States, California, Florida and New Jersey brought a False Claims Act case against Medco. The case claims Medco (now a part of Express Scripts) defrauded state and federal health insurance programs by accepting undisclosed discounts from drug manufacturers and not passing on the savings on to its clients. This case is ongoing.
2015	*HM Compounding Services v. Express Scripts*, Case No. 14-cv-01858 (E.D. Mo.)	Express Scripts is facing an antitrust conspiracy suit in which the plaintiff a compounding pharmacy, has alleged Express Scripts engaged in a conspiracy with other major PBMs to exclude competing compounding pharmacies from their network. As a result, competition within the compounding industry has been foreclosed and consumers have been routed to the PBMs captive pharmacies. The case is ongoing, and the plaintiffs have survived a motion to dismiss.
2015	*United States v. CVS* See: http://goo.gl/Ks3FqR	CVS was forced to **pay $22 million** to resolve federal allegations that its pharmacies sold narcotic painkillers not prescribed for legitimate medical purposes.
2014	*Grasso Enterprises, LLC, et.al., v. Express Scripts, Inc.*, Case No: 4:14-cv-01932 (E.D. Mo.)	Numerous compounding pharmacies sued Express Scripts alleging that the company intentionally cut compounding spending and illegally terminated compounding pharmacies from the Express Scripts' network. This case is ongoing.
2014	*United States ex rel. Well v. CVS Caremark, Inc.*, Civil Action No. SA:11-CV-00747 (W.D. Tex.).	The United States filed a False Claims Act suit against Caremark for knowingly failing to reimburse Medicaid for prescription drug costs paid on behalf of Medicaid beneficiaries who also were eligible for drug benefits under Caremark-administered private health plans. Caremark settled the case, **paying the federal**

		government $6 million.
2014	*Securities and Exchange Commission v. CVS Caremark Corp.*, Civil Action No. 14-177-ML (D.R.I.)	Stemming from 2009, CVS Caremark agreed to **pay $20 million** to settle charges brought by federal securities regulators that it misled investors and committed accounting violations.
2012	*Uptown Drug v. CVS Caremark*, Case No. 12-cv-6559 (N.D. Cal.)	Class of independent pharmacies filed suit against CVS Caremark alleging violations of California's unfair trade practice law by forcing maintenance prescriptions adjudicated by CVS Caremark's PBM business into CVS retail pharmacies, to the detriment of California pharmacies. The case is pending before the Ninth Circuit Court of Appeals.
2012	*In the Matter of CVS Caremark Co.*, FTC No. 112 31210	The Federal Trade Commission filed a complaint against CVS Caremark for misrepresenting the prices of certain Medicare Part D prescription drugs at CVS and Walgreens pharmacies. The misrepresentation caused seniors and disabled consumers to pay significantly more for critical medications. CVS Caremark settled, **paying refunds to 13,000 consumers for a total of $5 million.**
2009	*HHS v. CVS* See: https://goo.gl/tHlXcM	CVS agreed to **pay $2.25 million** to resolve allegations by both the Department of Health and Human Services and Federal Trade Commission that it violated the Health Insurance Portability and Accountability Act (HIPAA).
2008	*Washington v. Caremark Rx.*, No. 08-2-06098-5-SEA (Wash. Sup. Ct.)	29 attorney generals, including the Washington Attorney General, alleged that Caremark engaged in deceptive trade practices, did not inform clients of retained profits from drug switches, and improperly restocked and reshipped previously dispensed drugs. Caremark settled the matter **paying $41 million** to the states and agreed to a change in business practices.
2008	*In re Express Scripts, Inc. PBM Litigation*, No. 4:05-md-1672-HEA (E.D. Mo.)	Numerous states sued Express Scripts alleging numerous violations of consumer protections. The violations included deceptive business practices by illegally encouraging doctors to switch patients to different brand name medications and increased spreads and rebates from manufactures without passing the savings onto the plans. Express Scripts **paid $9.3 million** to settle the case, accepted restrictions on its drug switching practices, and adopted a code of professional standards.
2006	*United States of America v. Merck-Medco Managed Care*	A multistate whistle blower lawsuit filed against Medco for violations of both federal and state False Claims Acts alleging defrauding the government,

	L.L.C., et al., No.: 00-cv-737 (E.D. Pa.)	increasing drug prices, and failing to comply with state-mandated quality of care standards. Medco settled and **paid a total of $184.1 million**.
2005	*United States of America, et al. v. AdvancePCS, Inc.*, No. 02-cv-09236 (E.D. Pa.)	A whistleblower suit against Advanced PCS (now a part of CVS Caremark) alleged that Advanced received kickbacks from drug manufacturers, induced customers to sign contracts with the PBM, and submitted false claims. Along with a **$137.5 million in settlement**, Advanced received a five-year injunction and was forced to enter into a Corporate Integrity Agreement.

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BUSINESS INSIDER

These companies you've never heard of are about to incite another massive drug price outrage

LINETTE LOPEZ
SEP. 12, 2016, 9:27 AM

A Target store team member places an item back on the shelf near the pharmacy department at a Target store in Los Angeles, California August 18, 2009.

Reuters

It's easy to see why EpiPen has become the focus of America's fury over drug prices. It treats potentially deadly allergic reactions — for example, in a child who is stung by a bee — and its price has spiked by over 500% in a few years.

While it's easy to jump all over drugmakers, like EpiPen's maker, Mylan, other actors in the healthcare system ought to draw as much scrutiny.

One group of companies, called pharmaceutical-benefit managers, or PBMs, serve as middlemen, and they touch every part of the purchase of a prescription drug.

And now there's a growing realization, from Washington to Wall Street, that PBMs have been a big beneficiary of soaring drug prices burdening Americans — profits of the largest companies have doubled in recent years — even as they pitch their services as critical to controlling costs.

It's what one Wall Street analyst described as a "perverse incentive" in the business. A recent Morgan Stanley analysis showed that PBMs' earnings would take a direct hit if drug companies began to slow down on price hikes.

The biggest of these companies is Express Scripts, but PBM services are also provided by CVS Health, UnitedHealth Group, and several smaller companies. Because of their complexity and opacity, they've managed to dodge the kind of intense scrutiny that drugmakers are facing.

But that's changing, and it's bad news for the industry. PBMs are being sued by some customers for double-dealing, and they're now also starting to draw the attention of Congress. Perhaps the biggest threat of all: They're facing a backlash from America's largest employers, some of which are working on a way to rewire the system.

Below, we're going to try to explain how PBMs work for the more than 260 million Americans they serve, and because, unlike the other big companies, it is mostly a PBM, we're going to use Express Scripts to do this.

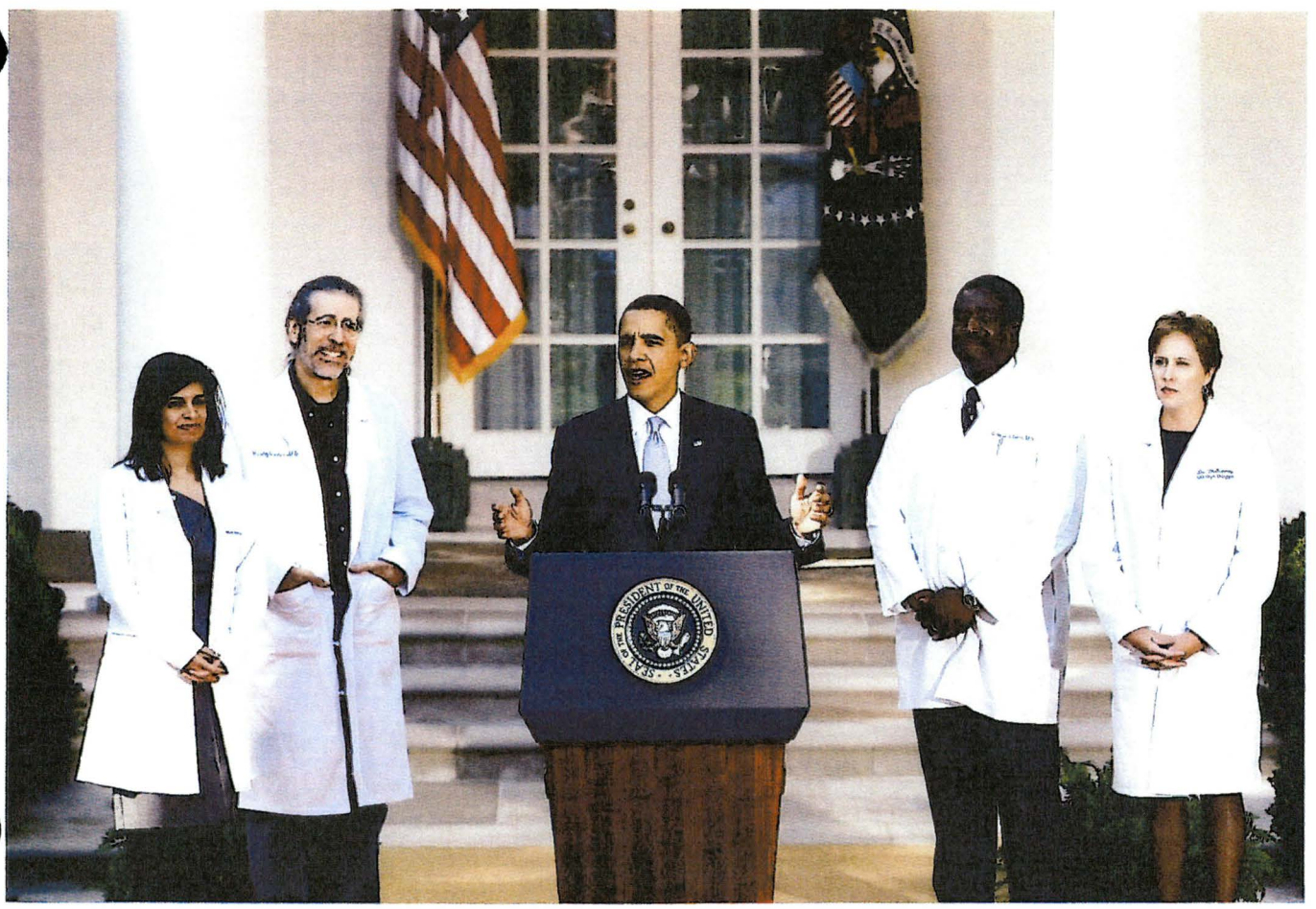
The ultimate middleman

Pharmaceutical-benefit managers started simply enough. In the 1960s, they served a need. As more Americans started taking prescription drugs, insurance companies were overwhelmed processing claims. PBMs offered to do it for them. PBMs pioneered plastic prescription cards and mail-order drug delivery.

They promised Americans they'd negotiate to keep drug prices down. They promised insurers they'd make processing prescriptions a lot cheaper and easier. And they promised drug companies they would favor certain drugs in exchange for rebates and price breaks.

They're paid fees by the insurers and employers who use their services. But they're also taking a cut of every sale. That alone isn't a problem. American business is full of middlemen, and nothing the PBMs do is illegal.

But where the PBMs are starting to get into trouble is that they're making bundles by keeping each player they deal with — pharmacies, insurers, drugmakers — partly in the dark. And those bundles, you could argue, are coming at the expense of the people who pay for healthcare.



Yes, Obamacare too.

Vin McNamee/Getty Images

Here's how a PBM like Express Scripts controls information and pricing.

Let's say a doctor prescribes you a heartburn drug. Its list price is $300, but the only people who pay that are those without insurance. Because you have insurance, you go to your local pharmacy and pay a $20 co-pay. For you, that's it. Your insurer might be paying $180 for the drug as part of a large-scale agreement it came to years ago via the PBM. The pharmacy that dispenses it may get only $160 for it. That $20 difference is a spread, and that goes to your PBM as profit. That's on top of fees your insurer is paying the PBM to administer its prescription-drug program.

That's the simplest way this goes down.

All the while, the pharmacy has no idea how much your insurer is paying for the drug, and your insurer isn't exactly sure how much the pharmacy is getting for dispensing the medicine. The drug company, meanwhile, isn't even getting close to the $300 list price that makes everyone so angry.

Then things get really murky.

If the price of the drug has increased, the PBM can be paid a rebate for the excess, which it pockets. The insurer, which is paying for the drug, won't know.

"These rebate amounts are less likely to be explicitly shared with a client," analysts at AllianceBernstein, an investment firm, wrote in a recent note on Express Scripts.

The note was written to answer the question of whether PBMs are "containing pharmacy costs or driving them." AllianceBernstein's answer was to put an "underperform" rating on Express Scripts' stock, warning of the risk to investors as people start to figure all this out.

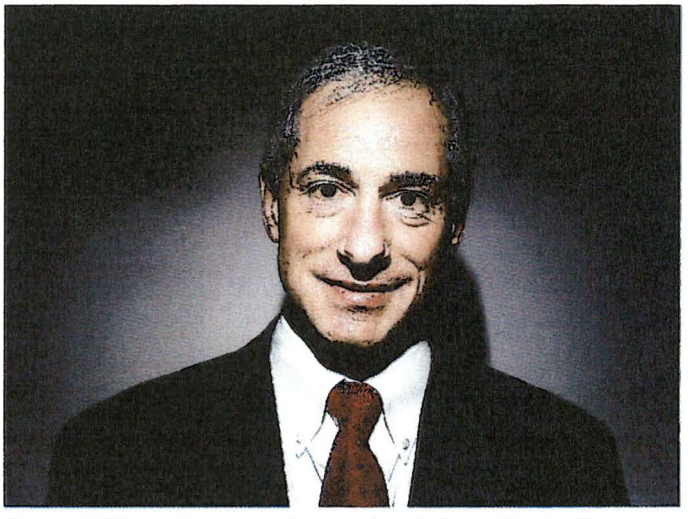
'What we don't want is transparency'

In the middle of the EpiPen news cycle, CNBC interviewed Steve Miller, the chief medical officer of Express Scripts.

"If she wanted to lower the price tomorrow she could," Miller said of Mylan's CEO, Heather Bresch.

He continued (emphasis added):

"We love transparency for our patients. Our patients should know exactly what they're going to pay when they go to the pharmacy counter. We love transparency for our clients — they can come in. They can audit their contracts. They know exactly what they're going to be required to pay ... **What we don't want is transparency for our competitors."**



Steve Miller, Express Scripts' chief medical officer.

Reuters

Did you catch that?

Express Scripts will tell clients how much they should pay, but it is trying hard not to tell anyone how much things cost. The problem is that when people find out, they seem to get very angry.

'Don't you find it odd?'

In February, at a congressional hearing about drug prices, Mark Merritt, the PBMs' lobbyist in Washington, was grilled by Republican Rep. Earl "Buddy" Carter of Georgia.

Carter owns a few small pharmacies, and he was getting very angry about the lists, called formularies, that PBMs develop for their clients. A formulary is a list of drugs that patients will be reimbursed for on a given plan.

PBMs also create maximum allowable cost (MAC) lists, which tell the drug companies and pharmacies how much they'll pay for a medication. The prices on each list can be different, but only the PBM knows the difference.

"They have one list here that they're going to reimburse the dispenser at. They have another list that they're going to charge the insurance company that they're representing," Carter said at the hearing. "Don't you find that somewhat awkward? Don't you find that to be a situation where the PBM could distort the market greatly?"

Merritt said he did not.

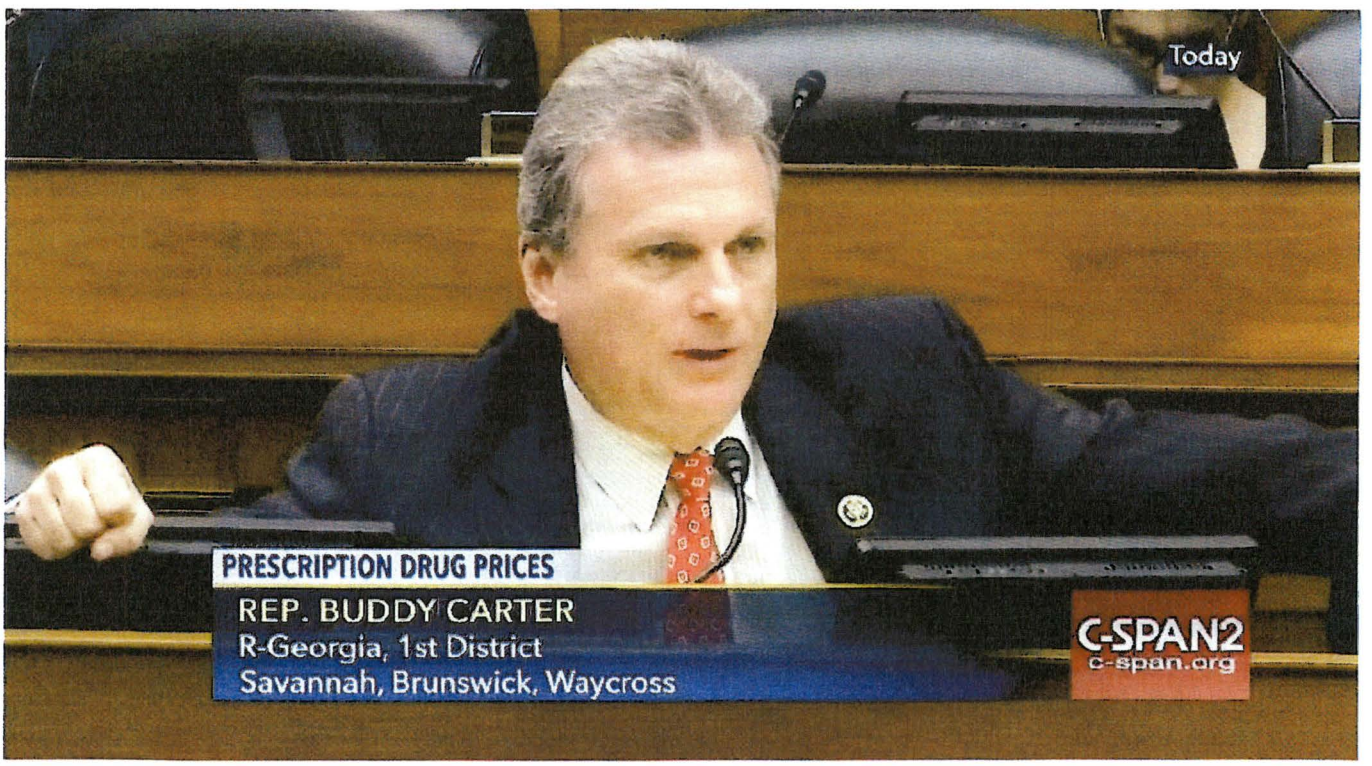
Carter also said that PBMs have caught the ire of states because they were not updating their MAC lists frequently enough. That means that even if a drug's cost increases for a pharmacy, the PBM still won't pay more to buy the drug for its clients.

Merritt insisted that it was not accurate.

Carter countered:

> "If that's the case, don't you find it somewhat odd that [the Centers for Medicare and Medicaid Services] found it necessary to mandate ... that these MAC lists be updated every seven days, and that 26 states have passed laws requiring PBMs to update their MAC lists? ... I notice that the profits of the PBMs have increased enormously over the past few years — in fact, almost doubled. I find that very disturbing, particularly when you're talking about spread pricing."

In a statement to Business Insider, Express Scripts said, "We update [MAC lists] on a regular basis ... as need be." It would not elaborate further.



C-Span, screenshot

Side hustles

Further complicating the issue with drug companies, PBMs have entered into businesses beyond just managing lists and buying drugs. Many have their own specialty pharmacies, which are mail-order pharmacies that manage drugs that are hard to distribute. Express Scripts, for example, has a specialty pharmacy called Accredo Health.

Carter says he has adjudicated claims for customers in his pharmacy, had them rejected, and then seen the PBM call the customer right away to tell them to use its specialty pharmacy.

"A mail-order pharmacy that is owned by the PBM — now don't you find that conflict of interest? Don't you find it a conflict of interest when a PBM not only owns the pharmacy but they're reimbursing here?" he asked.

What he means is that the PBM helps to manage the drugs on the formulary and negotiates the price of the drug that it could be buying from *itself*.

Express Scripts also has a business that manages patient-assistance programs called United BioSource. Drug companies use these assistance programs to help patients get around co-pays and often point to them when drug costs go up really fast. Express Scripts picks up a management fee for doling out this cash.

While all this complex stuff is going on in the background, the *patient's* price is being held steady. In his CNBC interview, Miller bragged that patients saw their EpiPen co-pay increase from $73.03 to just $73.50.

"We're really trying to protect our plans," he said.

What it really does, though, is protect all the players from patient outrage, because rising drug prices mean rising rebates and increasing profits for the PBM.

In a research note, Morgan Stanley analysts walked through what would happen with a single product: Allergan's chronic dry-eye treatment, Restasis.

The price of Restasis has increased by double digits annually in recent years, and so has the income generated from rebates related to it. If Allergan were to cut back on price hikes, like it just pledged to, those earnings would drop by 15%.

Of course, clients such as insurers don't know exactly how much drugs cost the PBM once it has negotiated its own rebate with a drug company; clients just know how much they're paying a PBM.

Are you seeing a trend here? Whether it's from drug companies like Mylan or PBMs, real prices are just hard to come by. And because their hands are in all corners of the business — the lists that get you to customers, the assistance programs that get customers to pay, the pharmacies that can sell you the drugs — that suits PBMs just fine.

Thomson Reuters

This is your brain — this is your brain on a PBM

With a market cap of $45.7 billion, Express Scripts is the largest of the PBMs and was created as a PBM, not an insurer or a pharmacy like its two primary competitors, UnitedHealth and CVS Health. The three control most of the PBM industry.

Based in St. Louis, Express Scripts exploded in 2011 when it announced it would purchase Medco Health Solutions for $29.1 billion. In 2010, before that deal, the company's revenue was $44.97 billion. In 2015, it was $101.75 billion.

We asked Express Scripts if it thought there were any conflicts of interest in the way its business is structured, conflicts that may prompt the company to add a drug to a formulary or stock it in its pharmacy (Accredo Health), for example.

Time and time again, the company said that clients make choices and Express Scripts just gives advice.

Here are a few of the answers we got:

Linette Lopez: If the price of a drug increases, doesn't payment to your company increase as well?

Express Scripts: All individual client contracts are geared toward driving down the cost of healthcare while creating the best possible outcomes for patients. Express Scripts' performance is contingent on our ability save our clients money while ensuring that patients have access to the right medications at the best possible price with the greatest level of care.

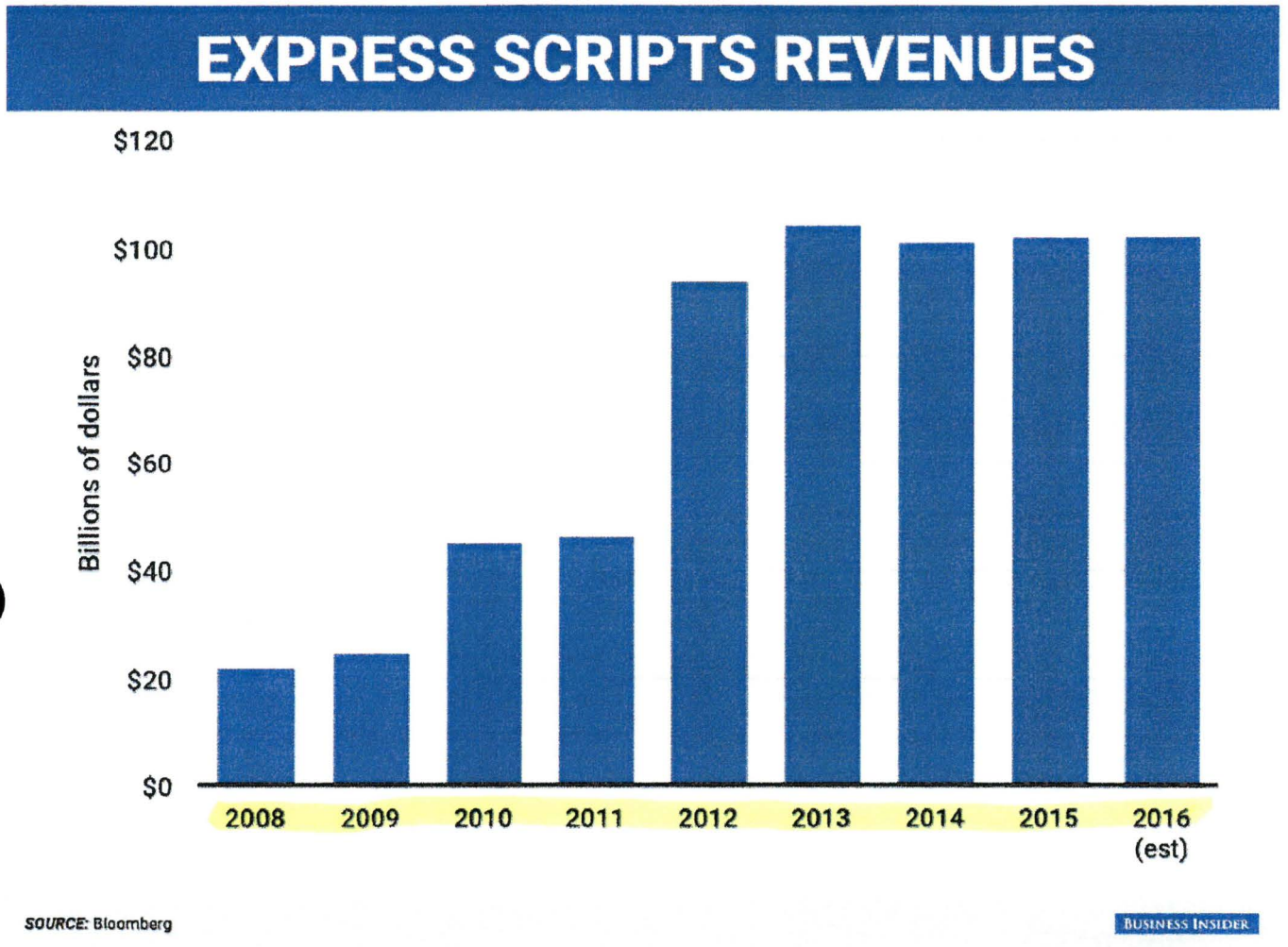
Lopez: Does Accredo sell drugs that it also provides patient-assistance programs for?

Express Scripts: Pharmaceutical manufacturers choose their PAP providers as well as their distribution channels. There are drugs dispensed by Accredo that have PAPs operated by [United BioSource]. For some

products, we determine eligibility and dispense the product, and for others the manufacturer contracts with Accredo to handle only dispensing.

Lopez: For what drug companies does United BioSource administer patient-assistance programs?

Express Scripts: [United BioSource] works with a number of manufacturers to implement PAPs to ensure that uninsured and underinsured patients who meet the qualifications of the program get access to the drugs they need. The number of companies is proprietary.



Business Insider

Dealing in the dark

What these answers reveal is that yes, sometimes Express Scripts gets paid for managing patient-assistance programs for drugs it also sells through its own pharmacy. So not only is the situation Carter described possible, patients won't even know what's going on because the patient-assistance program will mask all the cost for them.

And no, you cannot find out whom Express Scripts managing patient-assistance programs for.

And, by the way, no, Express Scripts does not "find it odd" (as Carter said) that it manages those two lists — one for what drug companies can charge and one for what clients have to pay.

"The client chooses how they would prefer to contract with us or any PBM for its service," the company told Business Insider. "Spread pricing is aligned with the payer's desire to control costs and our ability to do so. Through spread pricing, we offer lower rates and leverage our ability to secure better discounts from retail pharmacies over the life of the contract."

Many clients do not agree with this.

Earlier this year, some of America's biggest employers — including American Express, Macy's, Coca-Cola — created an organization called the Health Transformation Alliance with the aim of breaking with "existing marketplace practices that are costly, wasteful, and inefficient, all of which have resulted in employees paying higher premiums, copayments, and deductibles every year." And they have PBMs in their sights.

Here's Barron's magazine on one way they'll do this:

> "They'd do this by rewriting their pharmacy-benefit contracts to eliminate the undisclosed drug-price markups that supply much of the PBM industry's profits. Instead, the PBMs would mainly receive administrative fees, which would be significantly lower."

There's more. Express Scripts gets a significant chunk of its revenue from two clients: the Department of Defense and Anthem Insurance.

But Anthem is suing Express Scripts for breaching its 10-year contract with the company, alleging that it "failed to negotiate new pricing concessions in good faith." It's seeking $15 billion in legal damages.

A number of Anthem clients are also suing both Express Scripts and Anthem for the money they spent on overpriced healthcare.

In California, clients are suing Express Scripts for failing "to comply with statutory obligations to provide the state's clients with the results of a biannual survey of retail drug prices."

Express Scripts sent us its response to the Anthem case. Basically, it argues that it had a deal, and it accuses Anthem of being the one to violate the agreement.

The response is replete with redactions meant to protect the terms of its contract with the insurer. It's these redactions, these facts concealed by omissions, that AllianceBernstein believes puts the PBM industry in peril.

"We believe retail spread benefits from a lack of transparency and press/political investigation has the potential to reduce spread. We believe greater awareness of rebate levels or price protection rebates would increase necessary sharing with clients," the analysts wrote.

In other words, once America finds out how this business works, it's not going to like how this business works.

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The 'middlemen' responsible for high prescription drug p

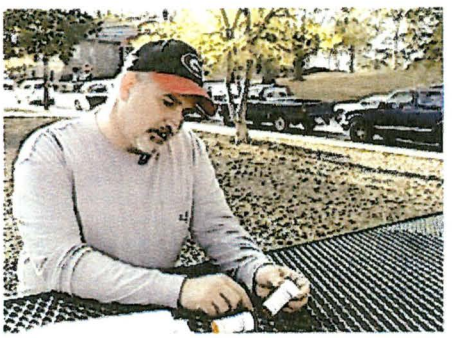
Andy Pierrotti, WXIA *2:45 PM. EST March 03, 2017*

(Photo: Pierrotti, Andy, WXIA)

The 11Alive Investigators uncover claims of prescription drug price gouging, not from pharmacies, but from a little known industry known as "middlemen" drug suppliers.

Those middlemen companies are called pharmacy benefit managers (PBMs). While you may have never heard of them before, pharmacists say PBMs play a big role in the price you pay for medicine, oftentimes setting prices the industry wants to keep secret from the public.

The healthcare industry call PBMs "middlemen" because they negotiate drug prices between insurance providers, drugmakers and pharmacies.



Randle Grizzle is no mathematician, but the Dahlonega resident knew things just didn't add up when he picked up two prescriptions late last year.

At first, he was charged $44 for ibuprofen and $75 dollars for a drug called tamsulosin. Those were the co-pays using his insurance.

"I said, 'How much is it without the co-pay, without fighting the insurance?'" Grizzle said.

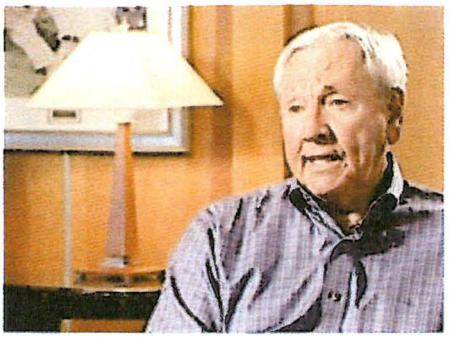
The cash price dropped from $44 to $13 for the ibuprofen and tamsulosin's price dropped 76 percent to just $18.

You read that correctly. Grizzle's own insurance tried to over-charged him, not the pharmacy. "So, a considerable difference," said Grizzle. "That doesn't make sense to me."

It's happening across the country. 11Alive News and our Minneapolis TEGNA partner, KARE 11, have found numerous examples of insurance co-pays costing more than out-of-pocket prices for prescription drugs.

RELATED | Who's Profiting from Prescription Overcharges
(http://www.kare11.com/news/investigations/whos-profiting-from-prescription-overcharges/347424661)

While Grizzle knew to ask for the out of pocket prices, the 11Alive Investigators uncovered pharmacists say they're are typically prohibited from talking to their patients about pricing options.



Eddie Madden is a former pharmacist in Elberton, where he owned a pharmacy for more than 40 years. Madden says contracts with PBMs prohibited him from talking about pricing.

"Well, I don't think it's right to the patient," said Madden. "What we see is a massive amount of money and no one has any assurance that it's actually getting back to reduce healthcare costs and healthcare dollars."

One contract, obtained by the 11Alive Investigators and KARE 11, have gag orders written in them. It states that pharmacists can get kicked out of an insurance network if they talk to the media or "sponsor's members" – which means customers – "without prior consent."

"It's par for the course in healthcare," said Dr. David Belk, who runs the consumer advocacy website, www.TrueCostofHealthcare.net (http://truecostofhealthcare.net/).

"Pharmacy benefit managers originally started in the 1990s when most drugs were brand name...but they morphed over the last few decades into this system that operates in the shadows and sets the own price for their own purposes," said Belk.

Express Scripts is the largest PBM in the U.S. According to SEC filings, its revenue jumped from $21 billion in 2006 to more than $100 billion in 2015. To put that in perspective, that's more revenue reported than McDonald's, Disney and Adidas – combined.

Interview requests with Express Scripts were declined, but its chief medical officer did respond to questions of influencing prices on CNBC last year following rising EpiPen prices.

RELATED | Full CNBC interview (http://www.cnbc.com/2016/08/25/mylan-can-lower-epipen-price-today-express-scripts-says.html)

> **CNBC:** *"So Steve, what Mylan CEO Heather Bresch said today, it's actually the middlemen who are responsible for incentivizing higher drug prices. How do you respond to that?"*
>
> **Steve Miller:** *"That can't be further from the truth. We would love to see lower drug prices. We pass the savings we take from the market back to our client."*

By email, Express Scripts also denies it hides prices from consumers – writing, *"the allegations you raised from the local pharmacists are inaccurate."*

Madden doesn't by that.

"No, I don't buy that because they're in the middle and I think they the problem there in the middle is that there's not transparency," said Madden.

"It makes you wonder where's the money's going," said Grizzle.

On Wednesday, March 1, Express Scripts sent 11Alive News a formal response via email noting several points:

“

- *Express Scripts does not engage in the anti-patient practice of copay clawbacks.*
- *The story implies the patient featured gets his benefit from Express Scripts. That person is not an Express Scripts member.*
- *We believe patients should pay the lowest possible price for a medication, and have a full line of site into their prescription costs and the opportunities they have to pay less.*
- *Via our website and mobile app, Express Scripts members always know -- in real-time -- what their specific cost will be for a prescription, based on their individual plan design, copay structure or current deductible status, before they fill their prescription.*
- *Our mobile and web tools tell our members if a medication will cost less at a different nearby pharmacy, in a different pharmacy channel, or if there is a less expensive clinical alternative they can discuss with their doctor. If their pharmacy's price for their medication is less than their copay, we tell them that, too.*
- *Our members do not have to pay cash, or go outside of their benefit, to pay a lower price if the pharmacy's price for the drug is less than their co-pay. The claim automatically processes at the lower cost, so the patient always pays the lower amount AND gets the clinical and safety protections that come with their pharmacy benefit.*
- *Express Scripts does not prohibit pharmacies from counseling patients on drug alternatives (including lower cost alternatives). We also do not prohibit pharmacies from disclosing the patient's out-of-pocket costs for a drug.*

Georgia lawmakers in Atlanta and Washington, D.C. plan action to address pricing and transparency with PBMs. Legislation in both chambers of the Georgia General Assembly passed on Wednesday addressing the issue.

WATCH PART 2 | How 'middlemen' force some small-town pharmacists out of business (http://www.11alive.com/news/investigations/side-effects/how-middlemen-force-some-small-town-pharmacists-out-of-business/413689910?c=n)

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LEAVE A COMMENT ()

5.3 **HIPAA**. [redacted] shall and Provider shall comply with all federal and state laws, rules, and regulations regarding the confidentiality of patient information, including, but not limited to, compliance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as amended ("HITECH Act"), including all applicable rules, regulations, and official guidance promulgated in connection with HIPAA and the HITECH Act, by the U.S. Department of Health and Human Services or otherwise.

5.4 **Remedies**. Provider acknowledges and agrees that any breach of Section 5 of this Agreement would cause [redacted] immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, if Provider fails to abide by the terms and conditions set forth in Section 5 of this Agreement, [redacted] shall be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the terms of this Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and to all other legal and equitable remedies available to [redacted].

6. **LIABILITY INSURANCE; INDEMNIFICATION AND LIABILITY**.

6.1 **Liability Insurance**. Provider shall obtain and maintain, and shall cause the Pharmacies to obtain and maintain, in full force and effect and throughout the Term of this Agreement, such policies of general liability, professional liability and other insurance of the types and amounts as are reasonably and customarily carried by pharmacies with respect to their operations, as further set forth in the Provider Certification and the Provider Manual. Upon [redacted] request, Provider shall provide [redacted] with evidence of such insurance coverage satisfactory to [redacted]. If the insurance purchased to satisfy the requirements of this Section 6.1 is "claims made", then Provider shall purchase an extended period of indemnity ("tail" coverage) so that [redacted] is protected from any and all claims brought against [redacted] for a period of not less than three (3) years subsequent to the date of termination of this Agreement.

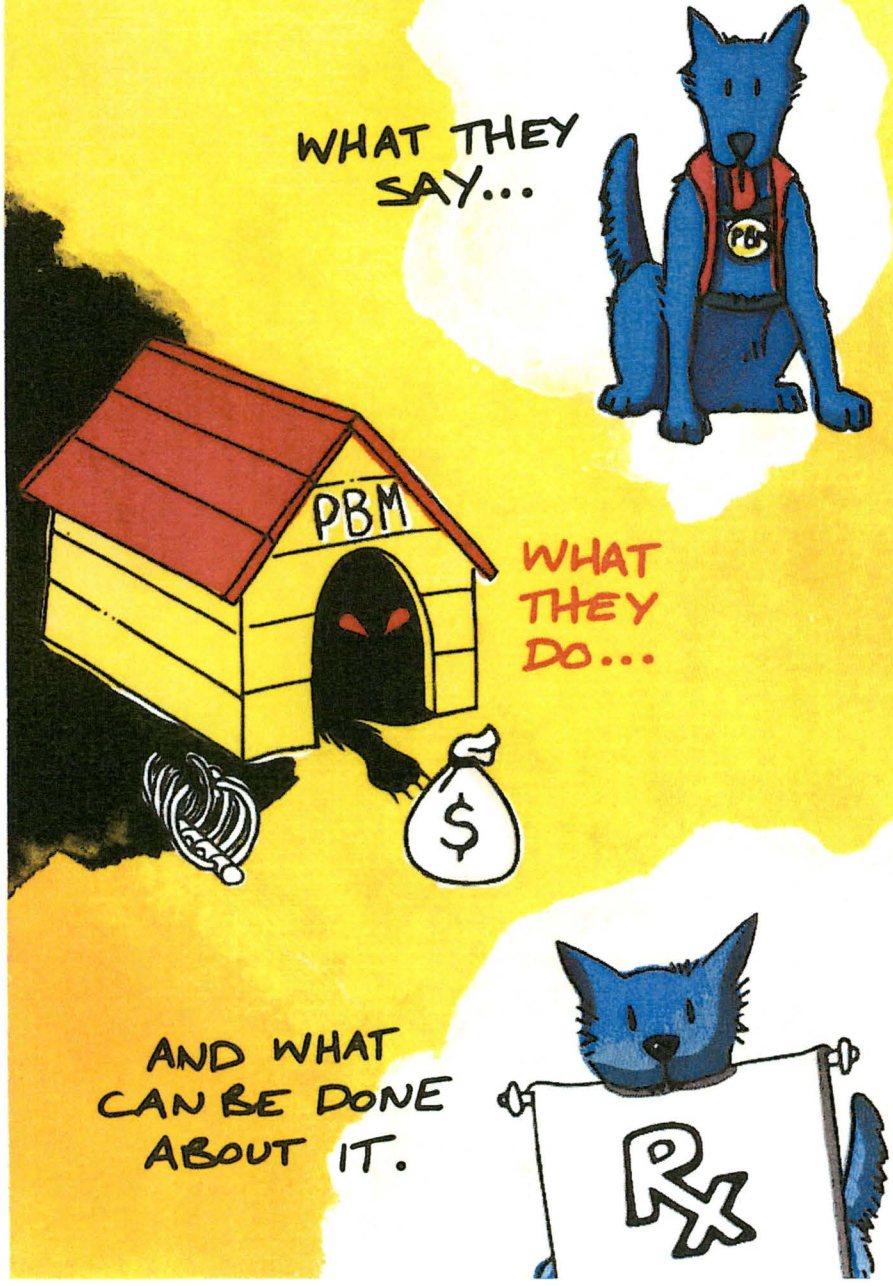
6.2 **Indemnification**. Provider shall indemnify and hold harmless [redacted] and its shareholders, officers, directors, employees, agents and affiliates from and against any and all claims, liabilities, losses, damages, costs, and expenses (including, without limitation, expert and professional fees and attorneys' fees) arising out of: (a) any breach by Provider of this Agreement; (b) the sale, compounding, dispensing, manufacturing, consultation or use of any prescription drug or any service provided by a Provider pursuant to this Agreement; (c) failure of Provider to act in accordance with generally accepted pharmacy practice or any applicable law, rules or regulation; or (d) any actual or alleged malpractice, negligence, misconduct, act (or failure to act) or responsibility of Provider related to dispensing and providing Covered Medications.

7. **MISCELLANEOUS PROVISIONS**.

7.1 **Contacting Sponsors or Media**. Provider hereby agrees (and shall cause its affiliates, employees, independent contractors, shareholders, members, officers, directors and agents to agree) that it shall not engage in any conduct or communications, including, but not limited to, contacting any media or any Sponsor and/or a Sponsor's Members or other party without the prior consent of [redacted]. Further, Provider acknowledges and agrees that any breach of this Section 7.1 by Provider (or any affiliate, employee, independent contractor, shareholder, member, officer, director or agent) would cause [redacted] immediate and irreparable injury or loss that cannot be fully remedied by monetary damages. Accordingly, in the event of a breach of this Section 7.1 by Provider (or any affiliate, employee, independent contractor, shareholder, member, officer, director or agent), [redacted] shall be entitled to specific performance, including immediate issuance of a temporary restraining order or preliminary injunction enforcing the terms of this Agreement, and to judgment for damages (including reasonable attorneys' fees and costs) caused by the breach, and to all other legal and equitable remedies available to [redacted].

7.2 **Notice**. Except as otherwise provided in this Agreement, any notice required to be given pursuant to the terms and conditions of this Agreement shall be in writing and: (a) delivered in person, evidenced by a signed receipt; (b) deposited in the United States mail, certified or registered, return receipt requested (or other similar method of delivery with a nationally recognized carrier (e.g., FedEx, UPS)); (c) delivered by facsimile, evidenced by a transmission receipt; or (d) delivered by email transmission to the email address listed below, as evidenced by a copy of the successful email transmission displaying such email address, to

The PBM Story



Decades ago, insurance companies expanded their coverage to include prescription drugs. They turned to a new kind of company, a sort of middleman, to process prescription drug claims.

For just a small fee per claim, these processors took care of all those prescription claims, not only for insurers, but also for self-insured employers and even certain state and federal government agencies—"plan sponsors" for short.

Everyone was happy: Plan sponsors had someone else to administer all those prescription claims, the claims processors made money providing the service, and patients had easy access to their medications at their neighborhood pharmacies.

As time passed, the middlemen began to exert more and more control over the consumer's prescription drug benefits. They developed formularies and told doctors and pharmacists which drugs they were allowed to give consumers and under what circumstances. They had morphed from something good and useful into large corporations intent on pursuing profits at the expense of quality patient care. They began to concentrate their power. Many smaller PBMs were gobbled up by larger ones. Others were purchased by plan sponsors themselves, or even by large drugstore chains.

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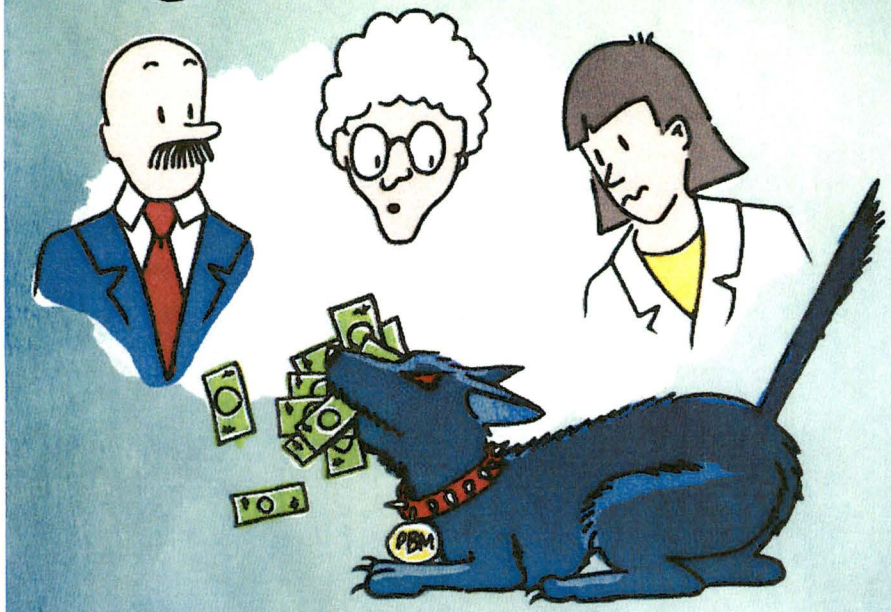
#3



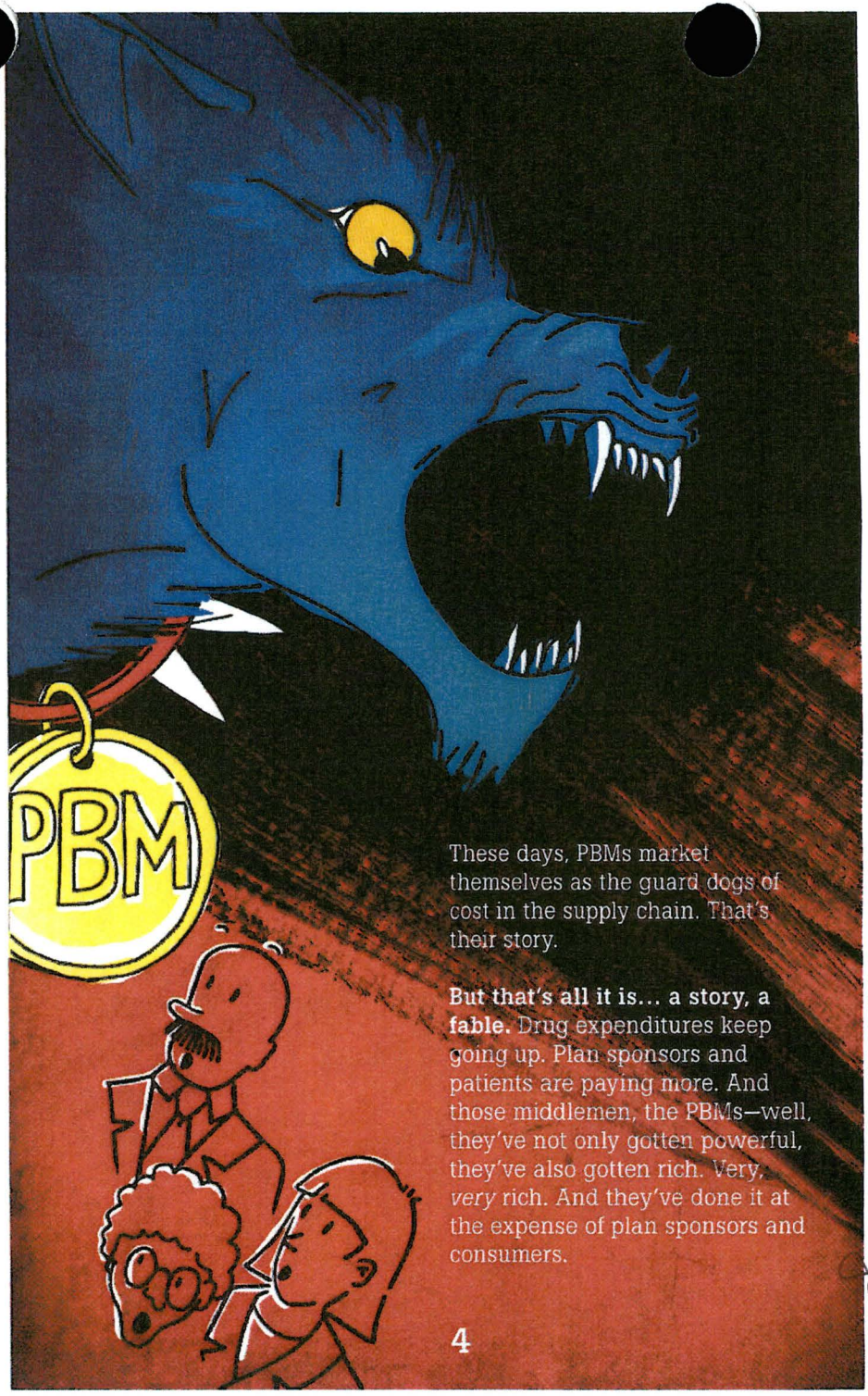
Pharmacists, patient groups, and policymakers expressed concern that all that consolidation and vertical integration was reducing competition and limiting patient choices. And they were right…

Today

PBMs control the pharmacy benefits of more than **253 MILLION Americans.**

After numerous acquisitions ***and consolidations,*** **Just 3 PBMs** now **CONTROL 78%** ***of prescription drug benefit*** *transactions in the U.S.*[1]

[1] Health Strategies Group, "Research Agenda 2015: Pharmacy Benefit Managers," http://www.healthstrategies.com/sites.default.files/PBM_Research_Agenda_PBM_RA_01513.pdf. Similar figures come from "Prescription Medicines: Costs in Context," August 2016, available at http://phrma-docs.phrma.org/sites/default/files/pdf/prescription-medicines-costs-in-context-extended.pdf.



These days, PBMs market themselves as the guard dogs of cost in the supply chain. That's their story.

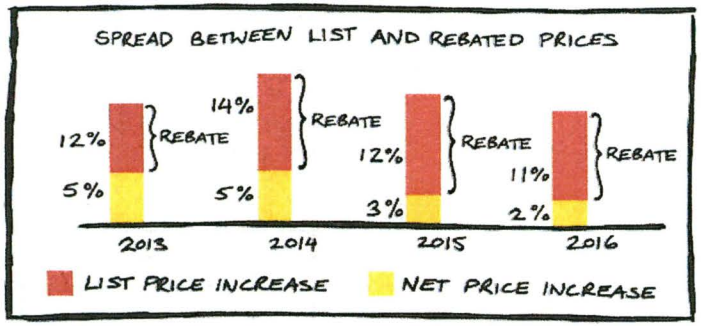
But that's all it is… a story, a fable. Drug expenditures keep going up. Plan sponsors and patients are paying more. And those middlemen, the PBMs—well, they've not only gotten powerful, they've also gotten rich. Very, *very* rich. And they've done it at the expense of plan sponsors and consumers.

Here's how they make money.

The main ways PBMs extract their profits is via rebates, administrative fees, and spread.

A **rebate** is a discount on a medication a drug *manufacturer* gives a PBM in return for the PBM agreeing to cover the drug manufacturer's product. Sometimes that means eliminating a less expensive, comparable medication from the formulary. Usually, only a portion of those rebates are shared with the plan sponsor. The PBM pockets the rest.

In recent years, rebates have exploded in magnitude. Today, roughly a third of the net price paid for medications is attributable to those rebates.[2] **In other words, a consumer's prescription may cost a good third more than it should due to rebates alone.**



Source: IMS Health, National Sales Perspectives. Mar 2016

"The problem is that our current system provides incentives for companies to push list prices higher, only to rebate the money later on the back end. Yet the rebates don't benefit consumers equally and they don't necessarily help offset the costs paid by those who need a particular drug."

~ FDA COMMISSIONER-DESIGNATE SCOTT GOTTLIEB IN OCTOBER 2016 TESTIMONY TO THE SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

[2] Derived from IMS Institute for Healthcare Informatics' April 2016 Report, "Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020."

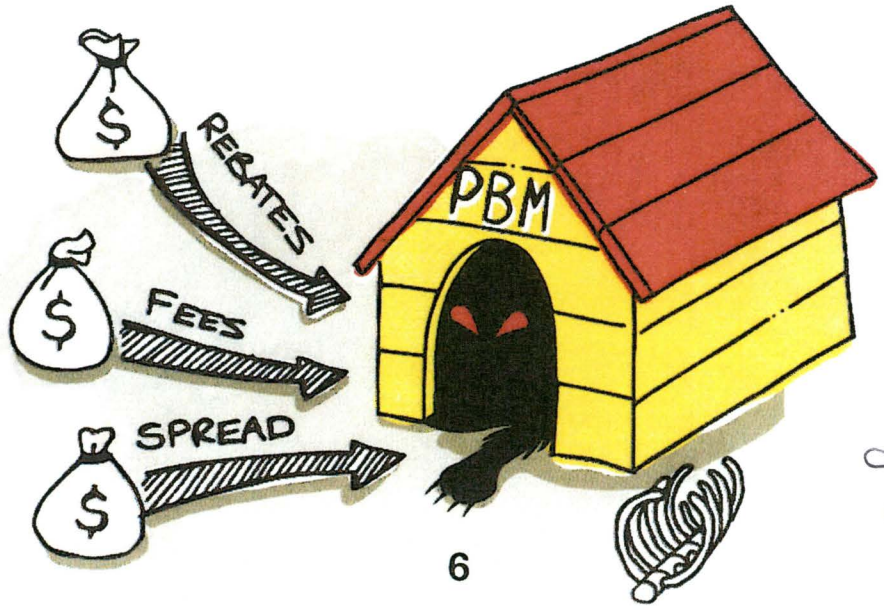
"I have never met, in this entire experience, a PBM or a payer outside of the Medicaid segment that preferred a price of $50,000 over $75,000 and a rebate back to them."

~ EXECUTIVE WITH PHARMA MANUFACTURER GILEAD SCIENCES, INC. AS QUOTED IN *BLOOMBERG NEWS*, MARCH 3, 2017

Rebates aren't the only charges PBMs extract. Often, they charge manufacturers and plan sponsors additional **fees and payments** that the PBM keeps for itself. Without full transparency, drug pricing is so complex that even the savviest of plan sponsors may not know all of the charges buried in their contracts. Those fees work to further drive up drug prices, too.

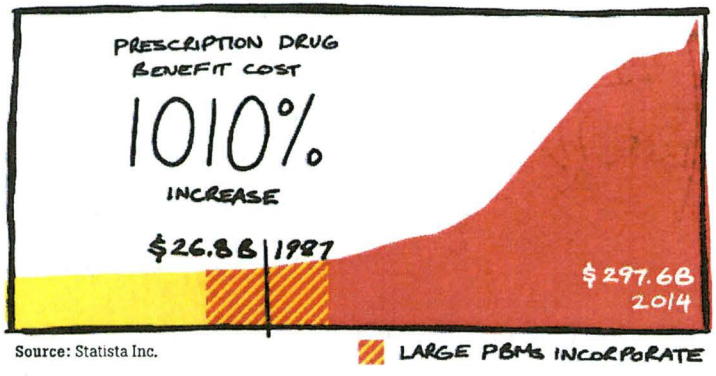
PBMs also make money on what's called **"the spread."** That's the practice of reimbursing the pharmacy one amount for a medication, charging the plan sponsor a higher price for the same drug, and pocketing the difference.

Often, plan sponsors don't know exactly how much more they are being billed for a drug than the pharmacy was reimbursed for it. They don't know this because of the complexity of pharmacy pricing and the lack of appropriate transparency—which, of course, advantage the PBM.



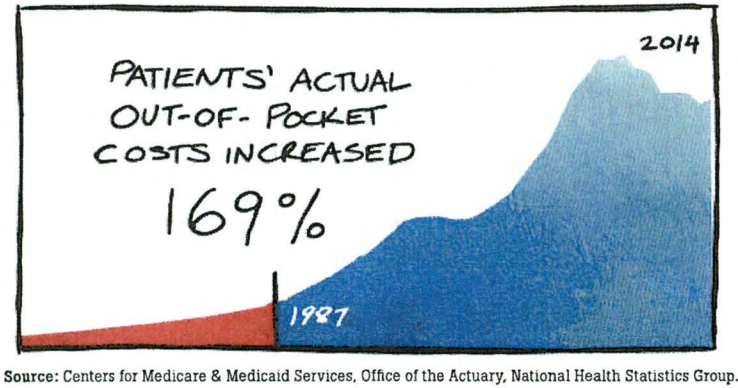
Here are some real numbers.

Today's largest PBMs say they lower prescription drug benefit costs for plan sponsors. Yet, since 1987, total spending on prescription drugs in the U.S. has increased 1,010 percent, from $26.8B to $297.6B. Overall price inflation in the U.S. only grew 125.9 percent in that same period.



Source: Statista Inc.

PBMs point out that patients' out-of-pocket expenses (copays, etc.) as a *percentage* of total prescription drug spend have been falling for decades. That's misleading, because total drug spend in *dollars* has risen precipitously in the same period. And in fact, the amount of money consumers themselves are paying for prescriptions has grown, not fallen. Indeed, actual *patient out-of-pocket costs have increased 169 percent* since 1987!



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

There's more.

Per-patient spending on prescription drugs has *continued* to rise dramatically—especially since 2014, when costly specialty drugs sky-rocketed and high-deductible insurance plans took off. Oddly, PBMs have been unable to control specialty drug spending, even while the two largest specialty pharmacies are owned by—you guessed it—PBMs. They fill specialty prescriptions at those PBM-owned pharmacies, and often *require* patients to use those pharmacies. The PBM-owned specialty pharmacy comes out all right in that transaction. But the plan sponsor and the patient? Not so much.

Generic medications saved **$1.68 TRILLION** *from 2005-2014.*[3]

TODAY generics account for 88% *of prescriptions dispensed,*[3] *up from 56% in 2005*[4]

Yet prescription ***drug spending overall continues to rise,*** *not fall.*

MORE RESULTS OF PBMS' "COST CONTROL"

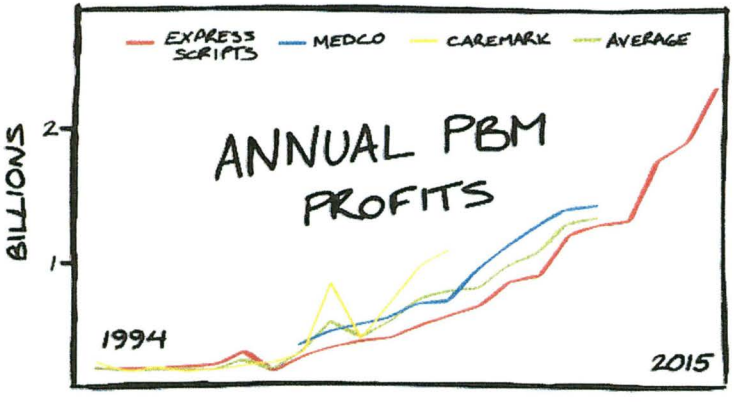
- Employers have seen a 1,553 percent increase in per-employee prescription drug benefit costs since 1987.[5]
- In the U.S., prescription drugs now account for nearly 10 percent of all national health care expenditures, up from 5.2 percent in 1987.[5]

[3] Generic Pharmaceutical Association. 2015 Annual Report.
[4] 2006 *NCPA Digest*.
[5] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

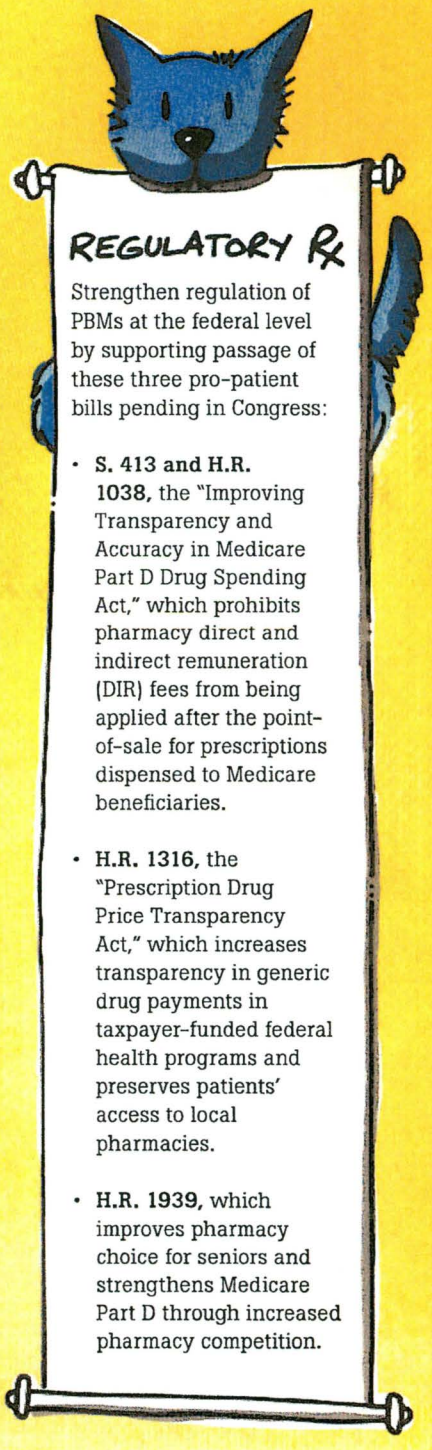
The largest PBM experienced an increase in net income of 70 percent in just two years, while the Bureau of Economic Analysis shows that after-tax corporate profits by other U.S. businesses remained virtually unchanged. According to one estimate, PBMs fail to pass $120 billion back to consumers, and retain another $30 billion in additional out-of-pocket costs.

~ "YOU CAN BLAME PHARMACY BENEFIT MANAGERS FOR HIGHER DRUG PRICES," *REAL CLEAR HEALTH*, MARCH 28, 2017

And the most damning fact of all: Thanks to the massive savings in newly available generic drugs, thanks to enormous increases in manufacturer rebates, and thanks to increased plan costs to employers and consumers, **PBM profits have increased exponentially.** The profits PBMs extract from the prescription drug supply chain actually *increase* prescription drug costs—*just the opposite of what PBMs claim.*



Source: Medco was owned by Merck from 1994-2003 and purchased by Express Scripts in 2012. Publicly available income statements are reported from 2001-2011. Caremark was purchased by CVS in 2006. Net income from publicly reported statements are reported from 1994-2006. Reported net income excludes negative values from discontinued operations reported on 10-K forms from 1995-2000. Express Scripts has been the sole independent major PBM with publicly available income statements since 2012.



Strengthen regulation of PBMs at the federal level by supporting passage of these three pro-patient bills pending in Congress:

- **S. 413 and H.R. 1038,** the "Improving Transparency and Accuracy in Medicare Part D Drug Spending Act," which prohibits pharmacy direct and indirect remuneration (DIR) fees from being applied after the point-of-sale for prescriptions dispensed to Medicare beneficiaries.
- **H.R. 1316,** the "Prescription Drug Price Transparency Act," which increases transparency in generic drug payments in taxpayer-funded federal health programs and preserves patients' access to local pharmacies.
- **H.R. 1939,** which improves pharmacy choice for seniors and strengthens Medicare Part D through increased pharmacy competition.

Here's a better story.

Think of it as a handful of prescriptions for what's ailing prescription health care costs in the U.S.

DEMAND TRANSPARENCY...
Sunlight, as they say, is the best disinfectant. In the short run, plan sponsors—employers, unions, and federal and state governments—deserve better cost control. They must require complete transparency from PBMs when it comes to direct and indirect revenues that the PBMs receive for administering that plan sponsor's prescription benefit plan.

CHANGE THE MODEL...
Another option for plan sponsors is to look at changing the model entirely: paying PBMs a simple flat fee (in total or per prescription) to administer the plan sponsor's chosen services. Properly structured, that model would eliminate hidden costs for plan sponsors and patients—costs that are at the heart of the continuing increases in prescription benefit spending. Another route some large self-insured employers have taken—Caterpillar, Inc., for instance—is for the company to act as its own prescription coordinator. Caterpillar has cut its annual prescription drug spend by tens of millions of dollars using this approach.

Page 5

LEAVE THE MIDDLEMAN, TAKE THE PHARMACIST...

Some companies are negotiating directly with pharmacy networks for prescription dispensing, as well as for patient care services. Working with community pharmacists to provide medication therapy and chronic disease management and wellness coaching, plan sponsors have seen extraordinary results in:

- Reducing emergency room visits
- Reducing hospital readmissions
- Evaluating for cost-effective options to lower patient prescription costs
- Identifying and preventing adverse drug interactions and side effects
- Increasing patients' medication adherence

Such plan sponsor-pharmacy partnerships are a two-fer. They've been proven to reduce not only the plan sponsor's prescription drug spend, but its overall health care costs as well.

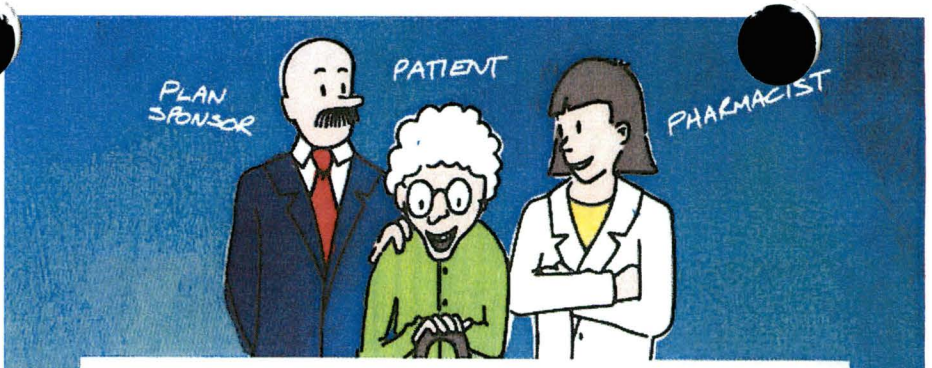
A 2010 systemic review of 298 studies found that pharmacist-provided services positively impacted patient outcomes and reduced health care spending across health care setting and disease states.

"One of the most evidence-based decisions to improve the health system is to maximize the expertise and scope of pharmacists and minimize expansion barriers of an already existing and successful health care delivery model."

– THE 2011 REPORT TO THE US SURGEON GENERAL FROM THE OFFICE OF THE CHIEF PHARMACIST

One community pharmacy in Iowa saved an insurer $2.4 million over 12 months for the care of just 600 patients.

Pharmacists decreased total direct medical costs by $1,200 to $1,872 per patient per year for employees of the city of Asheville with chronic diseases.



"Caterpillar's move away from benefit managers started when it suspected that as much as a quarter of its $150 million drug spending was wasted. The company devised its own list of drugs to offer its U.S. health-plan members and negotiated deals with pharmacies. It promoted generics and discouraged use of expensive heartburn and cholesterol medicines. The changes have saved the company $5 million to $10 million per year on cholesterol-lowering statins alone.... Drug spending at Caterpillar... has dropped per patient and per prescription since the company started the program."

– "DRUG COSTS TOO HIGH? FIRE THE MIDDLEMAN," *BLOOMBERG NEWS*, MARCH 3, 2017

When it comes to prescription drug prices, there's a better story than the one America has been told—and sold—by PBMs over the past quarter century.

By embracing appropriate transparency and new payment and patient care models, we can rewrite the story—so we can all live happier—and healthier—ever after.

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

100 DAINGERFIELD ROAD, ALEXANDRIA, VA 22314 800.544.7447 WWW.NCPANET.ORG

#4

HB1403

Lee, Judy E.

From: Ternes, Rebecca L.
Sent: Tuesday, April 11, 2017 12:43 PM
To: Fischer, Matt A.; Lee, Judy E.; Boschee, Joshua A.
Cc: Godfread, Jon; Ubben, Jeff R.; Moody, Edward J.; Behrens, Sara R.
Subject: RE: HB 1403 questions

Thanks Matt. This info needed to be described for the conference committee.

Rebecca L. Ternes
Director of Agency Operations
North Dakota Office of the Governor
701.328.2200 **www.governor.nd.gov**

From: Fischer, Matt A.
Sent: Tuesday, April 11, 2017 12:20 PM
To: Ternes, Rebecca L. <relternes@nd.gov>; Lee, Judy E. <jlee@nd.gov>; Boschee, Joshua A. <jboschee@nd.gov>
Cc: Godfread, Jon <jongodfread@nd.gov>; Ubben, Jeff R. <jrubben@nd.gov>; Moody, Edward J. <emoody@nd.gov>; Behrens, Sara R. <sbehrens@nd.gov>
Subject: RE: HB 1403 questions

Rebecca,

First question: If we did an exam of the insurer and found that the PBM was not following the contract, we would have no authority to do anything to remedy that situation. The insurer could take civil action.

Second question: We do not have the authority to enforce the Pharmacy Board sections of the code. A situation where we could take action against a PBM license would be where the Pharmacy Board found a violation of the Pharmacy Board sections and took action. If the Pharmacy Board then brought that violation to the Department's attention and the Commissioner found, in his discretion, that, based on that violation or conviction, the PBM is incompetent, untrustworthy, financially irresponsible or of poor reputation, we could revoke, suspend, or fine the PBM.

Our authority over a PBM is pretty limited.

Thanks,

Matt

From: Ternes, Rebecca L.
Sent: Tuesday, April 11, 2017 9:27 AM
To: Fischer, Matt A. <mattfischer@nd.gov>; Lee, Judy E. <jlee@nd.gov>; Boschee, Joshua A. <jboschee@nd.gov>
Cc: Godfread, Jon <jongodfread@nd.gov>; Ubben, Jeff R. <jrubben@nd.gov>; Moody, Edward J. <emoody@nd.gov>
Subject: RE: HB 1403 questions

Matt – As a part of an examination on an insurer mentioned below, what would occur if the PBM was not following the contract with the insurer?

Also, could you describe a situation where the Insurance Department WOULD have the authority to revoke the license of a PBM? Given the unfair trade practice sections on the Pharmacy Board sections of code (recently updated with the new PBM laws), would a separate private action or conviction impact a license?

Rebecca L. Ternes
Director of Agency Operations
North Dakota Office of the Governor
701.328.2200 **www.governor.nd.gov**

From: Fischer, Matt A.
Sent: Tuesday, April 11, 2017 9:19 AM
To: Lee, Judy E. <jlee@nd.gov>; Boschee, Joshua A. <jboschee@nd.gov>
Cc: Ternes, Rebecca L. <relternes@nd.gov>; Godfread, Jon <jongodfread@nd.gov>; Ubben, Jeff R. <jrubben@nd.gov>; Moody, Edward J. <emoody@nd.gov>
Subject: RE: HB 1403 questions

Senator Lee & Representative Boschee

The Department's authority over PBMs is very limited. Each PBM is required to be licensed with the Department and annually renew that license. The Department does not have the authority to examine a PBMs records and the Department has no meaningful authority to take action against a PBM if needed.

During each domestic health insurance company examination the statute requires the Department to check if the rebates are being applied as a reduction of price or a rebate to the insured.

Please let me know if you have any further questions.

Thanks,

Matt Fischer, CFE
Financial Analyst
North Dakota Insurance Department
mattfischer@nd.gov
701-328-9617

From: Ternes, Rebecca L.
Sent: Monday, April 10, 2017 4:13 PM
To: Moody, Edward J.
Cc: Lee, Judy E.; Boschee, Joshua A.; Godfread, Jon
Subject: HB 1403 questions

Ed – I just left the HB 1403 PERS/PBM conference committee. After, Sen. Lee and Rep. Boschee had questions on the Insurance Department's authority over PBMs. I said I would pass on the request for the following information:

- A description of the Insurance Department's authority over PBMs doing business in the state
- The Department's ability to examine PBM records
- The Department's ability to take action against a PBM if needed

Thanks - RLT

Rebecca L. Ternes
Director of Agency Operations

Apr 13, 2017

17.0720.02006
Title.

Prepared by the Legislative Council staff for
Representative Kasper
April 12, 2017

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

That the Senate recede from its amendments as printed on pages 1226 and 1227 of the House Journal and pages 967-969 of the Senate Journal and that Engrossed House Bill No. 1403 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to transparency for public employee health benefits for prescription drug coverage; and to amend and reenact section 54-52.1-04.2 of the North Dakota Century Code, relating to self-insurance for public employee health benefits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52.1-04.2 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.2. Self-insurance plan for hospital ~~and~~, medical, and prescription drug benefits coverage.

1. ~~The board may establish~~This section applies to a self-insurance plan for ~~providing:~~

   a. ~~Health insurance~~hospital, medical, and prescription drug benefits coverage;

   b. ~~Health insurance~~hospital and medical benefits coverage, excluding all or part of prescription drug benefits coverage; or

   c. ~~All~~all or part of prescription drug benefits coverage. The board may establish a self-insurance plan under this section if the board determines a self-insurance plan is in the best interest of the state and the state's eligible employees.

2. ~~Any~~A self-insurance plan established by the board under this section must be provided under an administrative services only (ASO) contract or a third-party administrator (TPA) contract under the uniform group insurance program~~, and may be established only if it is determined by the board that an administrative services only or third-party administrator plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits. Upon establishing~~.

3. If the board establishes a self-insurance plan, the ~~board shall solicit bids for an~~term of the contract for administrative services only or a third-party administrator ~~contract only every other biennium, and the board is authorized to~~must be for two years and the board may renegotiate ~~an existing administrative services only or third-party administrator contract during the interim. In addition,~~the contract for one additional two-year term. The board shall solicit bids for the contract for administrative services only or a third-party administrator at least once every four years. If the board

establishes a self-insurance plan, the board shall make individual stop-loss coverage insured by a carrier authorized to do business in this state ~~must be made~~ part of ~~any self-insured~~the plan. ~~All bids under this section are due no later than January first, and must be awarded no later than March first, preceding the end of each biennium.~~If the board solicits bids under this section, the board shall solicit bids for a contract for insurance or a health maintenance organization, or both. The board may transition from a self-insurance plan to a contract for insurance or a health maintenance organization if the board determines the transition would be in the best interest of the state and the state's eligible employees. All bids received by the board under this section must be opened at a public meeting of the board.

SECTION 2. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

1. This section applies to a board contract for prescription drug coverage that utilizes the services of a pharmacy benefits manager, either directly with the pharmacy benefits manager or indirectly through a carrier.

2. If the services of the pharmacy benefits manager are contracted indirectly through a carrier, the terms of the contract between the carrier and the board must provide the carrier shall provide the board a copy of the contract between the carrier and the pharmacy benefits manager, and if the contract is revised or a new pharmacy benefits manager contract is entered, within thirty days of the change the carrier shall provide the board with a copy of the revision or new contract.

3. The terms of the contract entered by the board for prescription drug coverage must provide:

   a. The pharmacy benefits manager shall provide the board with a complete set of monthly claims data and information on all programs implemented, including prior authorization, step therapy, mandatory generic, and quantity limit programs. The information must include a report on any program modification made during the reported month.

   b. The board, in the board's discretion, may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are or are not covered; the formulary; and the programs identified in subdivision a.

   c. The board has full audit rights as provided under this section, including the right to audit the pharmacy benefits manager and the right to conduct an audit in connection with rebates and other financial benefits provided to the carrier or pharmacy benefits manager, or both, by drug manufacturers and other third parties.

4. At least annually, the board shall conduct an audit under this section which must verify all terms of the prescription drug coverage contract are being satisfied. An audit conducted under this section must include, without limitation:

a. A review of a complete set of prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.

b. A determination whether all pricing terms and guarantees in the pharmacy benefits management contract were satisfied.

c. A review of rebates and other financial benefits provided to the carrier or pharmacy benefits manager, or both, by drug manufacturers or other third parties.

d. A review of all prescription drug programs implemented during the audit period, including a review of all modifications made to the plans during the audit period. In connection with each program the audit must include:

(1) A report on modifications made to the programs during the audit period;

(2) A list of each drug covered by each program and specifics about each drug; and

(3) A report on each program on the cost; the cost savings or avoidance; member disruption; the process for and number of overrides, approvals, and disapprovals; and clinical outcomes.

e. Recommendations relating to:

(1) Proposed changes to the copayment, coinsurance, deductibles, or out-of-pocket limit requirements; drugs that are or are not covered; the formulary; and programs that are implemented.

(2) Proposed changes to the prescription drug coverage contract.

(3) Proposed changes to decrease costs and improve benefits for plan beneficiaries.

5. If the auditor is unable to conduct a complete audit under this section due to lack of access to necessary information, and this noncompliance is not remedied in a timely manner, the board may find the carrier or the pharmacy benefits manager in breach of the contract with the board. If an audit conducted under this section identifies errors, any related financial liabilities of the pharmacy benefits manager or the carrier are to be paid directly to the board.

6. Information provided to the board under the contract provisions or an audit conducted under this section is confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts."

Renumber accordingly

4/14/17 1

17.0720.02007
Title.

Prepared by the Legislative Council staff for
Representative Kasper
April 13, 2017

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

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   c. ~~All~~all or part of prescription drug benefits coverage. The board may establish a self-insurance plan under this section if the board determines a self-insurance plan is in the best interest of the state and the state's eligible employees.

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2. If the services of the pharmacy benefits manager are contracted indirectly through a carrier, the terms of the contract between the carrier and the board must provide the carrier shall provide the board a copy of the contract between the carrier and the pharmacy benefits manager, and if the contract is revised or a new pharmacy benefits manager contract is entered, within thirty days of the change the carrier shall provide the board with a copy of the revision or new contract.

3. The terms of the contract entered by the board for prescription drug coverage must provide:

   a. The pharmacy benefits manager shall provide the board with a complete set of monthly claims data and information on all programs implemented, including prior authorization, step therapy, mandatory generic, and quantity limit programs. The information must include a report on any program modification made during the reported month.

   b. The board, in the board's discretion, may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are or are not covered; the formulary; and the programs identified in subdivision a.

   c. The board has full audit rights as provided under this section, including the right to audit the pharmacy benefits manager and the right to conduct an audit in connection with rebates and other financial benefits provided to the carrier or pharmacy benefits manager, or both, by drug manufacturers and other third parties.

4. At least biennially, the board shall conduct an audit under this section which must verify all terms of the prescription drug coverage contract are being satisfied. An audit conducted under this section must include, without limitation:

a. A review of a complete set of prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.

b. A determination whether all pricing terms and guarantees in the pharmacy benefits management contract were satisfied.

c. A review of rebates and other financial benefits provided to the carrier or pharmacy benefits manager, or both, by drug manufacturers or other third parties.

d. A review of all prescription drug programs implemented during the audit period, including a review of all modifications made to the plans during the audit period. In connection with each program the audit must include:

(1) A report on modifications made to the programs during the audit period;

(2) A list of each drug covered by each program and specifics about each drug; and

(3) A report on each program on the cost; the cost savings or avoidance; member disruption; the process for and number of overrides, approvals, and disapprovals; and clinical outcomes.

e. Recommendations relating to:

(1) Proposed changes to the copayment, coinsurance, deductibles, or out-of-pocket limit requirements; drugs that are or are not covered; the formulary; and programs that are implemented.

(2) Proposed changes to the prescription drug coverage contract.

(3) Proposed changes to decrease costs and improve benefits for plan beneficiaries.

5. If the auditor is unable to conduct a complete audit under this section due to lack of access to necessary information, and this noncompliance is not remedied in a timely manner, the board may find the carrier or the pharmacy benefits manager in breach of the contract with the board. If an audit conducted under this section identifies errors, any related financial liabilities of the pharmacy benefits manager or the carrier are to be paid directly to the board.

6. Information provided to the board under the contract provisions or an audit conducted under this section is confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts."

Renumber accordingly

Apr 18, 2017

1

17.0720.02008
Title.

Prepared by the Legislative Council staff for
Representative Kasper
April 17, 2017

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

That the Senate recede from its amendments as printed on pages 1226 and 1227 of the House Journal and pages 967-969 of the Senate Journal and that Engrossed House Bill No. 1403 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to transparency for public employee health benefits for prescription drug coverage; to amend and reenact section 54-52.1-04.2 of the North Dakota Century Code, relating to self-insurance for public employee health benefits; and to provide for application.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 54-52.1-04.2 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.2. Self-insurance plan for hospital ~~and~~, medical, and prescription drug benefits coverage.

1. ~~The board may establish~~This section applies to a self-insurance plan for ~~providing:~~

   a. ~~Health insurance~~hospital, medical, and prescription drug benefits coverage;

   b. ~~Health insurance~~hospital and medical benefits coverage, excluding all or part of prescription drug benefits coverage; or

   c. ~~All~~all or part of prescription drug benefits coverage. The board may establish a self-insurance plan under this section if the board determines a self-insurance plan is in the best interest of the state and the state's eligible employees.

2. ~~Any~~A self-insurance plan established by the board under this section must be provided under an administrative services only (ASO) contract or a third-party administrator (TPA) contract under the uniform group insurance program~~, and may be established only if it is determined by the board that an administrative services only or third-party administrator plan is less costly than the lowest bid submitted by a carrier for underwriting the plan with equivalent contract benefits. Upon establishing~~.

3. If the board establishes a self-insurance plan, the ~~board shall solicit bids for an~~term of the contract for administrative services only or a third-party administrator ~~contract only every other biennium, and the board is authorized to~~must be for two years and the board may renegotiate ~~an existing administrative services only or third-party administrator contract during the interim. In addition,~~the contract for one additional two-year term. The board shall solicit bids for the contract for administrative services only or a third-party administrator at least once every four years. If the board

establishes a self-insurance plan for hospital and medical benefits coverage, the board shall make individual stop-loss coverage insured by a carrier authorized to do business in this state ~~must be made~~ part of ~~any self-insured~~the plan. ~~All bids under this section are due no later than January first, and must be awarded no later than March first, preceding the end of each biennium.~~If the board solicits bids under this section, the board shall solicit bids for a contract for insurance or a health maintenance organization, or both. The board may transition from a self-insurance plan to a contract for insurance or a health maintenance organization if the board determines the transition would be in the best interest of the state and the state's eligible employees. All bids received by the board under this section must be opened at a public meeting of the board.

SECTION 2. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Prescription drug coverage - Transparency - Audits - Confidentiality.

1. This section applies to a board contract for prescription drug benefits coverage that utilizes the services of a pharmacy benefits manager, either directly with the pharmacy benefits manager or indirectly through a carrier.

2. If the services of the pharmacy benefits manager are contracted indirectly through a carrier, the terms of the contract between the carrier and the board must provide the carrier shall provide the board a copy of the contract between the carrier and the pharmacy benefits manager, and if the contract is revised or a new pharmacy benefits manager contract is entered, within thirty days of the change the carrier shall provide the board with a copy of the revision or new contract.

3. The terms of the contract entered by the board for prescription drug coverage must provide:

   a. The pharmacy benefits manager shall provide the board with a complete set of monthly claims data and information on all programs implemented, including prior authorization, step therapy, mandatory generic, and quantity limit programs. The information must include a report on any program modification made during the reported month.

   b. The board, in the board's discretion, may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are or are not covered; the formulary; and the programs identified in subdivision a.

   c. As provided under this section, the board has full audit rights relating to the prescription drug coverage offered as part of the uniform group insurance program, including, as it relates to the prescription drug coverage, the right to audit the pharmacy benefits manager and the right to conduct an audit in connection with rebates and other financial benefits provided to the carrier or pharmacy benefits manager, or both, by drug manufacturers and other third parties.

4. At least once during the first two years of a new contract, the board shall conduct a comprehensive audit under this subsection which must verify all

terms of the prescription drug coverage contract are being satisfied. A comprehensive audit conducted under this subsection must include, without limitation:

a. A review of a complete set of prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.

b. A determination whether all pricing terms and guarantees in the pharmacy benefits management contract were satisfied.

c. A review of rebates and other financial benefits provided to the carrier or pharmacy benefits manager, or both, by drug manufacturers or other third parties.

d. A review of all prescription drug programs implemented during the audit period, including a review of all modifications made to the plans during the audit period. In connection with each program the audit must include:

(1) A report on modifications made to the programs during the audit period;

(2) A list of each drug covered by each program and specifics about each drug; and

(3) A report on each program on the cost; the cost savings or avoidance; member disruption; the process for and number of overrides, approvals, and disapprovals; and clinical outcomes.

e. Recommendations relating to:

(1) Proposed changes to the copayment, coinsurance, deductibles, or out-of-pocket limit requirements; drugs that are or are not covered; the formulary; and programs that are implemented.

(2) Proposed changes to the prescription drug coverage contract.

(3) Proposed changes to decrease costs and improve benefits for plan beneficiaries.

5. In addition to the comprehensive audit required in the case of a new contract under subsection 4, regardless of whether the contract is new or renewed the board shall conduct a comprehensive audit or consecutive partial audits as the board determines prudent. Regularly, the board shall review prescription drug claims experience. In determining the frequency and the content of an audit under this subsection, the factors considered by the board must include consideration of the prescription drug claims experience.

6. If the auditor is unable to conduct a complete audit under this section due to lack of access to necessary information, and this noncompliance is not remedied in a timely manner, the board may find the carrier or the pharmacy benefits manager in breach of the contract with the board. Upon a finding of breach by the board, the board may renegotiate the contract with the existing carrier or pharmacy benefits manager to remedy the breach or terminate the contract. Notwithstanding any other provision of

law, if the board terminates the contract under this section before the expiration of the contract term, the board may contract directly with a replacement carrier or pharmacy benefits manager without soliciting a bid or meeting other applicable contract term restrictions.

7. If an audit conducted under this section identifies errors, any related financial liabilities of the pharmacy benefits manager or the carrier are to be paid directly to the board.

8. Information provided to the board under the contract provisions or an audit conducted under this section is confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts.

SECTION 3. APPLICATION. Section 2 of this Act applies to retirement board contracts for prescription drug coverage entered or renewed by the board after July 31, 2017."

Renumber accordingly

Apr 19, 2017

17.0720.02009
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
April 18, 2017

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1403

That the Senate recede from its amendments as printed on pages 1226 and 1227 of the House Journal and pages 967-969 of the Senate Journal and that Engrossed House Bill No. 1403 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee prescription drug coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Prescription drug coverage.

If the board solicits bids for prescription drug coverage and receives a bid for coverage that would utilize the services of a pharmacy benefits manager, the board may give preference to a bid that would allow the board to audit the services provided by that pharmacy benefits manager which are related to the board contract for prescription drug coverage. This section applies regardless of whether the prescription drug coverage is bundled with hospital and medical benefits coverage or is in a separate contract."

Renumber accordingly