

CHAPTER 26.1-27.1
PHARMACY BENEFITS MANAGEMENT

26.1-27.1-01. Definitions.

In this chapter, unless the context otherwise requires:

1. "Covered entity" means a nonprofit hospital or a medical service corporation; a health insurer; a health benefit plan; a health maintenance organization; a health program administered by the state in the capacity of provider of health coverage; or an employer, a labor union, or other entity organized in the state which provides health coverage to covered individuals who are employed or reside in the state. The term does not include a self-funded plan that is exempt from state regulation pursuant to the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.]; a plan issued for coverage for federal employees; or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care, or other limited-benefit health insurance policy or contract.
2. "Covered individual" means a member, a participant, an enrollee, a contractholder, a policyholder, or a beneficiary of a covered entity who is provided health coverage by the covered entity. The term includes a dependent or other individual provided health coverage through a policy, contract, or plan for a covered individual.
3. "De-identified information" means information from which the name, address, telephone number, and other variables have been removed in accordance with requirements of title 45, Code of Federal Regulations, part 164, section 512, subsections (a) or (b).
4. "Generic drug" means a drug that is chemically equivalent to a brand name drug for which the patent has expired.
5. "Labeler" means a person that has been assigned a labeler code by the federal food and drug administration under title 21, Code of Federal Regulations, part 207, section 20, and that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.
6. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:
 - a. A rebate collected by the pharmacy benefits manager which is allocated to a covered entity;
 - b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;
 - c. A pharmacy network fee; and
 - d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.
7. "Pharmacy benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation within this state to covered individuals; the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals; or the providing of any of the following services with regard to the administration of the following pharmacy benefits:
 - a. Claims processing, retail network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;
 - b. Clinical formulary development and management services; or
 - c. Rebate contracting and administration.
8. "Pharmacy benefits manager" means a person that performs pharmacy benefits management. The term includes a person acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term does not include a public self-funded pool or a private single-employer self-funded plan that provides benefits or services directly

to its beneficiaries. The term does not include a health carrier licensed under title 26.1 if the health carrier is providing pharmacy benefits management to its insureds.

9. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.
10. "Utilization information" means de-identified information regarding the quantity of drug prescriptions dispensed to members of a health plan during a specified time period.

26.1-27.1-02. Licensing.

A person may not perform or act as a pharmacy benefits manager in this state unless that person holds a certificate of registration as an administrator under chapter 26.1-27.

26.1-27.1-03. Disclosure requirements.

1. A pharmacy benefits manager shall disclose to the commissioner any ownership interest of any kind with:
 - a. Any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the pharmacy benefits manager provides services.
 - b. Any parent company, subsidiary, or other organization that is related to the provision of pharmacy services, the provision of other prescription drug or device services, or a pharmaceutical manufacturer.
2. A pharmacy benefits manager shall notify the commissioner in writing within five business days of any material change in the pharmacy benefits manager's ownership.

26.1-27.1-04. Prohibited practices.

1. A pharmacy benefits manager shall comply with chapter 19-02.1 regarding the substitution of one prescription drug for another.
2. A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one contract in order to participate in another contract. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in a particular network if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.

26.1-27.1-05. Contents of pharmacy benefits management agreement - Requirements.

1. A pharmacy benefits manager shall offer to a covered entity options for the covered entity to contract for services that must include:
 - a. A transaction fee without a sharing of a payment received by the pharmacy benefits manager;
 - b. A combination of a transaction fee and a sharing of a payment received by the pharmacy benefits manager; or
 - c. A transaction fee based on the covered entity receiving all the benefits of a payment received by the pharmacy benefits manager.
2. The agreement between the pharmacy benefits manager and the covered entity must include a provision allowing the covered entity to have audited the pharmacy benefits manager's books, accounts, and records, including de-identified utilization information, as necessary to confirm that the benefit of a payment received by the pharmacy benefits manager is being shared as required by the contract.

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

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

2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract with a pharmacy benefits manager and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.
3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1.

26.1-27.1-07. Rulemaking authority.

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