State PBM Reform Inventory

Updated October 2026

North Dakota

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Insurance Commissioner to operate in the state. Operating as an unlicensed PBM is considered a class C felony. PBM licenses must be renewed each year. The commissioner shall establish application and renewal forms as well as initial application and renewal fees not to exceed $10,000.	N.D. Cent. Code § 26.1-27.1-02
Reporting Requirements	A PBM shall disclose to the commissioner any ownership interest of any kind with any insurance company responsible for providing benefits to any plan for which the PBM provides services. A PBM shall also disclose any ownership interest with 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. The commissioner shall examine contracts between covered entities (including insurers) and PBMs to determine whether rebates, discounts, and other fees transmitted to the covered entities have been applied to reduce the covered entities' rates or distributed to covered individuals. Covered entities shall annually disclose any payments received from PBMs and how those payments are applied to reduce rates or distributed to covered individuals. Contracts between covered entities and PBMs shall provide the covered entity the right to audit the PBM's books, accounts, and records, including de-identified utilization information, as necessary to confirm that the benefit of a payment received by the PBM is being shared as required by the contract. If requested by a plan sponsor contracted payer, a PBM that has an ownership interest, either directly or through an affiliate or subsidiary, in a pharmacy shall disclose to the plan sponsor contracted payer any difference between the amount paid to a	N.D. Cent. Code § 26.1-27.1-03; N.D. Cent. Code § 26.1-27.1-05; N.D. Cent. Code § 26.1-27.1-06; N.D. Cent. Code §19-02.1-16.2

	pharmacy and the amount charged to the plan sponsor contracted payer.	
PBM Income	**Rebate Pass-Through:** PBMs shall offer covered entities several options for the treatment of rebates in their contracts, including a model where the PBM passes all payments received to the covered entity.	N.D. Cent. Code § 26.1-27.1-05
Pharmacy Contracting	**MAC Pricing:** These MAC pricing requirements do not apply to the state Medicaid program. A PBM shall not place a drug on a MAC list unless: • The drug has at least two nationally available, therapeutically equivalent, multiple source drugs, or a generic drug is available only from one manufacturer; • The drug is listed as therapeutically equivalent and pharmaceutically equivalent or "A" or "B" rated in the United States food and drug administration's most recent version of the "Orange Book" or the drug is "Z" rated; and • The drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete. With respect to each contract between a PBM and a pharmacy, each PBM shall: • Provide to the pharmacy, at the beginning of each contract and contract renewal, the sources utilized to determine the MAC pricing of the PBM. • Update any MAC price list at least every 7 business days and provide prompt notification of the pricing changes to network pharmacies. • Disclose the sources utilized for setting MAC price rates on each MAC price list included under the contract and identify each MAC price list that applies to the contracted pharmacy. A PBM shall make the list of the MACs available to a contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy. • Ensure MAC prices are not set below sources utilized by the PBM. • Provide a reasonable administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable price rate. The PBM shall provide a	N.D. Cent. Code § 19-02.1-14.2; N.D. Cent. Code §19-02.1-16.2

	determination to a provider that has contested a maximum allowable price rate within 7 business days. If an update to the maximum allowable price rate for an appealed drug is warranted, the PBM shall make the change based on the date of the determination and make the adjustment effective for all similarly situated pharmacy providers in this state within the network. • Ensure dispensing fees are not included in the calculation of MAC price reimbursement to pharmacy providers. **Patient Steering:** A PBM or a PBM's affiliates or subsidiaries may not own or have an ownership interest in a patient assistance program and a mail order specialty pharmacy, unless the PBM, affiliate, or subsidiary agrees to not participate in a transaction that benefits the PBM, affiliate, or subsidiary instead of another person owed a fiduciary duty.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A PBM or third-party payer may not charge a patient a copayment that exceeds the cost of the medication. **Copay Cap:** A PBM may not require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount exceeding the out-of-pocket limits below: • Covered insulin drugs may not exceed $25 per 30-day supply per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs. • Covered medical supplies for insulin dosing and administration may not exceed $25 per 30-day supply per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs. **Copay Adjustment Programs:** When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement for a prescription drug under the health benefit plan, the health benefit plan must provide for the inclusion of any amount paid	N.D. Cent. Code § 19-02.1-16.1; N.D. Cent. Code § 26.1-36-09.16; N.D. Cent. Code § 26.1-36-09.17

	by the enrollee or paid on behalf of the enrollee by another person. The health benefit plan may not vary the out-of-pocket maximum or cost-sharing requirements or otherwise design benefits that account for the availability of a cost-sharing assistance program for a prescription drug. The requirements under this section do not apply with respect to an HSA-eligible high-deductible health plan until a covered individual meets their minimum deductible.	