HOUSE BILL NO. 276

INTRODUCED BY E. GREEF

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING REIMBURSEMENT CONDITIONS FOR A NETWORK PHARMACY OR PHARMACIST TO ALLOW OPTING OUT IF ACQUISITION COSTS ARE NOT COVERED; CLARIFYING PHARMACEUTICAL REIMBURSEMENT COVERAGE TO INCLUDE HEALTH INSURANCE ISSUERS; DEFINING "REFERENCE PRICING"; AMENDING SECTIONS 20-15-403, 33-22-170, AND 33-22-172, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Application.** The provisions of 33-22-170 through 33-22-173, [section 5], and this section apply to health insurance issuers and plan sponsors, including the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

Section 2. Section 20-15-403, MCA, is amended to read:

"20-15-403. Applications of other school district provisions. (1) When the term "school district" appears in the following sections outside of Title 20, the term includes community college districts and the provisions of those sections applicable to school districts apply to community college districts: 2-9-101, 2-9-111, 2-9-316, 2-16-114, 2-16-602, 2-16-614, 2-18-703, 7-3-1101, 7-6-2604, 7-6-2801, 7-7-123, 7-8-2214, 7-8-2216, 7-11-103, 7-12-4106, 7-13-110, 7-15-4206, 10-1-703, 15-1-101, 15-6-204, 15-16-101, 15-16-605, 15-70-401, 17-5-101, 17-5-202, 17-6-103, 17-6-204, 17-6-205, 17-6-213, 17-7-201, 18-1-201, 18-2-101, 18-2-103, 18-2-113, 18-2-114, 18-2-401, 18-2-404, 18-2-432, 18-5-205, 19-1-102, 19-1-811, 19-20-302, 22-1-309, 25-1-402, 27-18-406, 33-20-1104, [section 1], 39-3-104, 39-4-107, 39-31-103, 39-31-304, 39-71-116, 39-71-117, 39-71-2106, 40-6-237, 49-3-101, 49-3-102, 50-71-112, 52-2-617, 53-20-304, 82-10-201 through 82-10-203, 85-7-2158, and 90-6-208 and Rules 4(k) and 15(c), M.R.Civ.P., as amended.

(2) When the term "school district" appears in a section outside of Title 20 but the section is not listed

in subsection (1), the school district provision does not apply to a community college district."

Section 3. Section 33-22-170, MCA, is amended to read:

"33-22-170. Definitions. As used in 33-22-170 through 33-22-173 and [sections 1 and 5], the following definitions apply:

(1) "Maximum allowable cost list" means the list of drugs used by a pharmacy benefit manager that sets the maximum cost on which reimbursement to a network pharmacy or pharmacist is based.

(2) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy pursuant to Title 37, chapter 7.

(3) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7, and that has entered into a network contract with a pharmacy benefit manager, health insurance issuer, or plan sponsor.

(4) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of ~~an insurer~~ a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, and pay pharmacies or pharmacists for prescription drugs.

(5) "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most current nationally recognized reference price or amount to set the reimbursement for prescription drugs and other products, supplies, and services covered by a network contract between a plan sponsor, health insurance issuer, or pharmacy benefit manager and a pharmacy or pharmacist."

Section 4. Section 33-22-172, MCA, is amended to read:

"33-22-172. Maximum allowable cost or reference price list -- price formulation, updating, and disclosure -- exceptions. (1) At the time it enters into a contract with a pharmacy and subsequently upon request, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall provide the pharmacy with the sources used to determine the pricing for the maximum allowable cost list or the reference used for reference pricing.

(2) ~~A~~ If using a maximum allowable cost list, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update the price information for each drug on the maximum allowable cost list at least

once every 10 calendar days to reflect any modification of pricing;

(b) establish a process for eliminating products from the maximum allowable cost list or modifying the prices in the maximum allowable cost list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(c) provide a process for each pharmacy to readily access the maximum allowable cost list specific to the pharmacy in a searchable and usable format.

(3) If using reference pricing, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update no less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used; and

(b) provide a process for each pharmacy to readily access the reference pricing specific to the plan sponsor or the health insurance issuer's plan.

(4) A plan sponsor, health insurance issuer, or pharmacy benefit manager may not prohibit a pharmacist from discussing reimbursement criteria with a patient."

NEW SECTION. **Section 5. Opt-out of reference pricing -- notification.** (1) A pharmacist or pharmacy in a network plan with a plan sponsor, health insurance issuer, or pharmacy benefit manager providing covered drugs on a reference pricing basis may decline to provide a brand-name drug, multisource generic drug, supply, or service if the reference pricing amount is less than the acquisition cost paid by the pharmacy or pharmacist.

(2) If a pharmacist or pharmacy declines to provide the prescription or service under the conditions in subsection (1), the pharmacy or pharmacist shall attempt to provide the customer with adequate information as to where the prescription for the drug, supply, or service may be filled.

(3) (a) The insurance commissioner may investigate and review on a random basis to determine whether a plan sponsor, health insurance issuer, or pharmacy benefit manager has an adequate network of pharmacies or pharmacists, particularly in rural areas, and whether mail-order pharmacies in a network are adequate to serve rural areas if a local pharmacy or pharmacist is unavailable.

(b) A pharmacy or pharmacist who declines to provide the prescriptions or service as provided in subsection (2) shall cooperate with any investigation and review of network adequacy.

NEW SECTION. **Section 6. Codification instruction.** [Sections 1 and 5] are intended to be codified

as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [sections 1 and 5].

NEW SECTION. **Section 7. Effective date -- applicability date.** [This act] is effective January 1, 2018, and applies to insurance policies and plans issued and in effect on or after January 1, 2018.

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