HOUSE BILL NO. 740

INTRODUCED BY M. BERTOGLIO, M. THANE, Z. WIRTH

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATING TO PHARMACIES, PHARMACY BENEFIT MANAGERS, AND OTHER ENTITIES; PROVIDING LAWS RELATING TO THE RECOUPMENT OF FUNDS; PROVIDING DEFINITIONS; REVISING LAWS RELATED TO MAXIMUM ALLOWABLE COST OR THE REFERENCE PRICE LIST; PROHIBITING CERTAIN FEES; AND AMENDING SECTIONS 33-2-2005, 33-22-170, 33-22-171, 33-22-172, 33-22-175, AND 33-22-177~~, AND 39-71-727~~, MCA."

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

Section 1. Section 33-2-2005, MCA, is amended to read:

"**33-2-2005. Prohibitions -- recoupment -- payment -- interest.** An entity conducting an audit may not:

(1) include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a dispensing error by the pharmacy, or the identified overpayment is based solely on an extra dispensing fee;

(2) recoup funds for prescription clerical or recordkeeping errors, including typographical errors, scrivener's errors, and computer errors, in a required document or record unless the error results in actual financial harm to the entity or to a consumer;

(3) collect any funds, charge-backs, or penalties until the audit and all appeals are final unless the entity is alleging fraud or other intentional or willful misrepresentation that is evidenced by the review of claims data, statements, physical review, or other investigative methods;

(4) use extrapolation or other statistical expansion techniques in calculating the amount of any recoupment or penalty;

(5) pay the agent or employee who conducted the audit based on a percentage of the amount recovered; ~~or~~

(6) charge interest during the audit period; or

(7) recoup funds on the basis of the timing of purchases of dispensed medication, but instead shall permit a pharmacy to use drug purchase records without limitation of date or source to validate the dispensing of legend or narcotic drugs so long as the purchase of the drug was done in accordance with state or federal law."

Section 2. Section 33-22-170, MCA, is amended to read:

"**33-22-170. Definitions.** As used in 33-22-170 through 33-22-177 and 33-22-180, the following definitions apply:

(1) "Contract pharmacy" means a pharmacy operating under contract with a federally certified health entity to provide dispensing services to the federally certified health entity.

(2) "Effective rate contracting" means an agreement or arrangement between a pharmacy or a contracting agent acting on behalf of a pharmacy and a pharmacy benefit manager or third-party payer that establishes a reimbursement rate for pharmaceuticals based on the effective rate of payment rather than on a predetermined fixed price or a fixed discount percentage.

~~(2)~~ (3) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

~~(3)~~ (4) "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.

~~(4)~~ (5) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy pursuant to Title 37, chapter 7.

~~(5)~~ (6) "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.

~~(6)~~ (7) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, pay pharmacies or pharmacists for prescription drugs, or provide other prescription drug or device services.

~~(7)~~ (8) "Pharmacy performance measurement entity" means:

(a) the electronic quality improvement platform for plans and pharmacies; or

(b) an entity approved by the board of pharmacy provided for in 2-15-1733 as a nationally recognized and unbiased entity that assists pharmacies in improving performance measures.

~~(8)~~ (9) "Pharmacy services administrative organization" means an entity that acts as a contracting agent or provides contracting and other administrative services to pharmacies to assist them in their interactions with third-party payers and pharmacy benefit managers.

~~(9)~~ (10) "Prescription drug" means any drug that is required by federal law or regulation to be dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq.

~~(10)~~ (11) "Prescription drug order" has the meaning provided in 37-7-101.

~~(11)~~ (12) "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 3. Section 33-22-171, MCA, is amended to read:

"**33-22-171. Maximum allowable cost list -- limitations on drugs.** Before a pharmacy benefit manager places or continues a drug on a maximum allowable cost list, the drug:

(1) must be listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations or have an "NR" or "NA" rating by a nationally recognized reference;

(2) must be available for purchase by pharmacies in this state from national or regional wholesalers; and

(3) may not be obsolete, temporarily unavailable, or listed on a drug shortage list."

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 of entering into a contract with a pharmacy or a pharmacy services

administrative organization and subsequently upon request, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall provide the pharmacy or pharmacy services administrative organization with the sources used to determine the pricing for the maximum allowable cost list or the reference used for reference pricing.

(2) 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, ensuring that maximum allowable cost increases are processed and updated on the same schedule as decreases;

(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~~ daily the price information for each drug, product, supply, or service for which reference pricing is used, updating reference pricing on the same date of the change in the referenced source; 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:

(a) prohibit a pharmacist from discussing reimbursement criteria with a covered person;

(b) penalize a pharmacy or a pharmacist for disclosing the information described in subsection (4)(a) to a covered person or for selling a more affordable alternative to a covered person; or

(c) require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy.

(5) (a) A plan sponsor, pharmacy benefits manager, or third-party payer shall ensure that

reimbursement to pharmacies for each drug dispensed is no less than 106% of the national average drug acquisition cost plus a professional dispensing fee that is no less than the fee-for-service rate employed by the Montana department of public health and human services authority for the Medicaid program. The national average drug acquisition cost price must be the price published in effect for the day the drug claim was billed by the pharmacy.

(b) In the event that a particular drug does not have a published national average drug acquisition price, the reimbursement must be:

(i) for generic drugs, 110% of published wholesale acquisition costs plus a professional fee of that is no less than the fee-for-service rate employed by the Montana department of health and human services authority for the Medicaid program; and

(ii) for brand-name drugs, 100% of wholesale acquisition costs plus a professional fee of that is no less than the fee-for-service rate employed by the Montana department of health and human services authority for the Medicaid program."

Section 5. Section 33-22-175, MCA, is amended to read:

"**33-22-175. Allowable and prohibited fees on pharmacies.** (1) A pharmacy benefit manager, ~~or~~ a third-party payer, or a discount card processor may not directly or indirectly charge or hold a pharmacy responsible for a fee, ~~related to a claim~~ including but not limited to the following:

(a) a fee for submission of a claim;

(b) any other claim-related fee;

(c) a fee for enrollment or participation in a retail pharmacy network;

(d) a credentialing or recredentialing fee;

(e) a fee for the development or management of claims processing services or claims payment services; or

(f) a fee on remittance advice or a fee that is retroactive ~~if the fee is not apparent at the time the claim is processed;~~

~~(b) if the fee is not reported on the remittance advice of an adjudicated claim; or~~

~~(c) after the initial claim is adjudicated~~.

~~(2) A pharmacy benefit manager or third-party payer may collect a performance-based fee from a pharmacy only if the pharmacy fails to meet the criteria established by a pharmacy performance measurement entity. The fee may be applied only to the professional dispensing fee outlined in the contract with the pharmacy and may not be imposed on the cost of goods sold by a pharmacy.~~

(3) Only criteria established by a pharmacy performance measurement entity may be used to measure a pharmacy's performance for the purposes of this section.

(4) A pharmacy benefits manager or third-party payer may not make or allow any reduction in payment for pharmacy services by a pharmacy benefits manager or third-party payer or directly or indirectly reduce a payment for a pharmacy service under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payments.

(5) All reimbursements to pharmacies must be made through direct bank transfers, checks, or other payment methods that do not incur processing fees for the pharmacy. Checks must have a 180-day expiration to deposit."

Section 6. Section 33-22-177, MCA, is amended to read:

"**33-22-177. Rights of pharmacies.** (1) A pharmacy benefit manager or third-party payer may not prohibit a pharmacist or pharmacy from:

(a) participating in a class-action lawsuit;

(b) disclosing to the plan sponsor or to the patient information regarding the adjudicated reimbursement paid to the pharmacy if the pharmacist or pharmacy complies with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1181 et seq.;

(c) providing relevant information to a patient about the patient's prescription drug order, including but not limited to the cost and clinical efficacy of a more affordable alternative drug if one is available;

(d) mailing or delivering a prescription drug to a patient as an ancillary service of a pharmacy if the practice is not prohibited under Title 37, chapter 7; or

(e) charging a shipping and handling fee to a patient who has asked that a prescription drug be mailed or delivered if the practice is not prohibited under Title 37, chapter 7.

(2) A pharmacy benefit manager or third-party payer may not:

(a) require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state; or

(b) exclude a pharmacy from the pharmacy benefit manager's or third-party payer's network based solely on the pharmacy being newly opened or open less than a defined amount of time, or because a license or location transfer occurs, unless there is a pending investigation for fraud, waste, or abuse.

(3) A pharmacist or pharmacy that belongs to a pharmacy services administrative organization may receive a copy of a contract the pharmacy services administrative organization entered into with a pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.

(4) A pharmacy benefit manager or third-party payer shall provide a pharmacy or pharmacist with the processor control number, bank identification number, and group number for each pharmacy network established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to make an informed contracting decision.

(5) (a) A pharmacy benefit manager shall:

(i) offer a pharmacy or a pharmacy services administrative organization an opportunity to renew an existing contract every 3 years, at a minimum; ~~and~~

(ii) allow a pharmacy or a pharmacy services administrative organization to terminate a contract upon a 90-day notice to the pharmacy benefit manager;

(iii) ensure pharmacy credentialing applications are processed and that pharmacies are added to applicable networks within 45 calendar days after all needed documentation has been submitted by the pharmacy or the pharmacy services administrative organization.

(iv) ensure pharmacy ownership changes are processed and that the pharmacy can process prescriptions for applicable networks within 30 calendar days after all needed documentation has been submitted by the pharmacy or the pharmacy services administrative organization.

(b) An addendum or amendment to an existing contract between a pharmacy benefit manager and a pharmacy or a pharmacy services administrative organization is effective only upon signing of the addendum or amendment by both parties.

(6) A pharmacy or a pharmacy services administrative organization has a private right of action to

enforce provisions of 33-22-175 through 33-22-177.

(7) Effective rate contracting is prohibited in all agreements between pharmacies or contracting agents acting on behalf of a pharmacy and a pharmacy benefit manager or third-party payer. A pharmacy benefit manager or third-party payer may not enter into any contract that establishes payment for services or medications based on an effective rate of reimbursement. A pharmacy benefit manager or third-party payer found to be in violation of this section is subject to penalties, including but not limited to fines, revocation of licensure, or other disciplinary actions.

(8) A pharmacy benefit manager may not:

(a) reimburse a network pharmacy an amount less than the contract price between the pharmacy benefit manager and the insurer, third-party payor, or the pharmacy services management organization the pharmacy benefit manager has contracted with; or

(b) require or coerce a patient to use a pharmacy that is owned by or affiliated with the pharmacy benefit manager.

(9) A pharmacy benefit manager shall apply the same utilization review, fees, copayments or cost-sharing, days allowance, and other conditions on a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the pharmacy benefit manager's pharmacy network, including mail-order pharmacies and the pharmacy benefit manager’s owned, affiliated, or preferred pharmacies.

(10) If a covered person is using a mail-order pharmacy, the pharmacy benefit manager shall allow for dispensing at local network pharmacies under the following circumstances to ensure patient access to prescription drugs:

(a) if the prescription is delayed more than 1 day after the expected delivery date provided by the mail-order pharmacy; or

(b) if the prescription drug arrives in an unusable condition as determined by the patient.

(11) A pharmacy benefit manager may not require the usage of mail order for a patient residing in an area where the U.S. postal service does not provide service delivery to a physical address."

~~Section 7.~~ ~~Section 39-71-727, MCA, is amended to read:~~

~~"**39-71-727. Payment for prescription drugs -- limitations.** (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless the generic-name drug is unavailable.~~

~~(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may bill the insurer only for the reimbursement rate of the generic-name drug.~~

~~(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemized billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).~~

~~(4) When billing for a brand-name drug, the pharmacist shall certify that the generic-name drug was unavailable.~~

~~(5) The department shall establish a schedule of fees for prescription drugs.~~

~~(6) Except as provided in subsection (8), a pharmacist may not dispense more than a 30-day supply at any one time.~~

~~(7) For purposes of this section, the terms "brand name" and "generic name" have the meanings provided in 37-7-502.~~

~~(8) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy. However, an insurer may authorize up to a 90-day supply of medications from an in-state mail service pharmacy.~~

~~(9) The provisions of this section do not apply to an agreement between a preferred provider organization and an insurer."~~

- END -