AN ACT CREATING THE MONTANA PHARMACY BENEFIT MANAGER OVERSIGHT ACT; ESTABLISHING LICENSURE REQUIREMENTS FOR PHARMACY BENEFIT MANAGERS; PROHIBITING CERTAIN PRACTICES; PROHIBITING UNTRUE, DECEPTIVE, OR MISLEADING ADVERTISING; REQUIRING TRANSPARENCY AND MAXIMUM ALLOWABLE COST REPORTING; PROVIDING FOR NETWORK ADEQUACY; AUTHORIZING ENFORCEMENT AND EXAMINATION AUTHORITY; EXPANDING THE MAXIMUM ALLOWABLE COST LAWS TO GROUP AND BLANKET POLICIES; PROVIDING RULEMAKING AUTHORITY; PROVIDING DEFINITIONS; AMENDING SECTIONS 33-17-102, 33-22-101, 33-22-170, 33-22-174, 33-30-102, 33-31-111, 33-35-306, 33-38-102, AND 39-71-2375, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE.

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

Section 1. Short title -- purpose. (1) [Sections 1 through 12] may be cited as the "Montana Pharmacy Benefit Manager Oversight Act".

(2) [Sections 1 through 12] establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers that provide claims processing services or other prescription drug or device services for health benefit plans and workers' compensation insurance carriers.

(3) The purpose of this act is to:

(a) promote, preserve, and protect the public health, safety, and welfare through regulation and licensure of pharmacy benefit managers;

(b) provide for powers and duties of the commissioner in licensing and regulating pharmacy benefit managers; and

(c) provide penalties for violations of [sections 1 through 12].

Section 2. Definitions. As used in [sections 1 through 12], the following definitions apply:

(1) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include either or both of the following:

(a) receiving payments for pharmacist services; and

(b) making payments to pharmacists or pharmacies.

(2) "Enrollee" means a member, policyholder, subscriber, covered person, beneficiary, dependent, or other individual participating in a health benefit plan.

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

(4) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) (a) "Health carrier" means an entity that is subject to the insurance laws and regulations of this state or to the jurisdiction of the commissioner and that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) The term includes:

(i) self-funded multiple employer welfare arrangements as defined in 33-35-103; and

(ii) any other entity providing a plan of health insurance, health benefits, or health care services.

(6) "Manufacturer" has the meaning provided in 37-7-602.

(7) "Other prescription drug or device services" means services other than claims processing services that are provided directly or indirectly, whether in connection with or separate from claims processing services, including but not limited to:

(a) negotiating rebates, discounts, or other financial incentives and arrangements with manufacturers, wholesale distributors, or other third parties;

(b) disbursing or distributing rebates;

(c) managing or participating in incentive programs or arrangements for pharmacist services;

(d) negotiating or entering into contractual arrangements with pharmacists, pharmacies, or both;

(e) developing and maintaining formularies;

(f) designing prescription drug benefit programs;

(g) advertising or promoting services; or

(h) administering prior authorization, step therapy, case management, or other utilization review programs.

(8) "Pharmacist" has the meaning provided in 33-22-170.

(9) "Pharmacist services" means products, goods, and services or any combination of products, goods, and services provided as part of the practice of pharmacy.

(10) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7.

(11) (a) "Pharmacy benefit manager" means a person, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to:

(i) enrollees who are residents of this state, for health benefit plans; or

(ii) injured workers of workers' compensation insurance carriers.

(b) The term does not include:

(i) a health care facility as defined in 50-5-101 that is licensed in this state;

(ii) a health care professional licensed under Title 37;

(iii) a consultant who provides advice only as to the selection or performance of a pharmacy benefit manager; or

(iv) a health carrier or workers' compensation insurance carrier to the extent that the carrier performs any claims processing and other prescription drug or device services exclusively for its enrollees or injured workers.

(12) "Plan sponsor" has the meaning provided in 33-10-202.

(13) (a) "Rebates" means all price concessions, however characterized, paid by a manufacturer to a pharmacy benefit manager, including discounts and other remuneration or price concessions, that are based on the actual or estimated utilization of a prescription drug.

(b) The term includes price concessions based on the effectiveness of a prescription drug as in a value-based or performance-based contract.

(14) "Wholesale acquisition cost" has the meaning provided in 42 U.S.C. 1395w-3a.

(15) "Wholesale distributor" or "distributor" has the meaning provided in 37-7-602.

(16) "Workers' compensation insurance carrier" means:

(a) an insurance company transacting business under compensation plan No. 2; or

(b) the state fund compensation plan No. 3 under Title 39, chapter 71.

Section 3. Licensing required. (1) A person may not perform an act or do business in this state as a pharmacy benefit manager without a valid license issued under [sections 1 through 12] by the commissioner.

(2) A license issued under [sections 1 through 12] is nontransferable.

(3) A pharmacy benefit manager shall apply to the commissioner on a form prescribed by the commissioner. At a minimum, the application form must include the following information:

(a) the name, business address, and telephone number of the pharmacy benefit manager and the name, address, and contact information for the principal contact person of the pharmacy benefit manager for communications with the commissioner on licensure-related matters;

(b) the name and address of:

(i) all members of the pharmacy benefit manager's board of directors, board of trustees, executive committee, or other governing board of committee;

(ii) the principal officers in the case of a corporation; or

(iii) the partners or members in the case of a partnership or association;

(c) proof of registration with the Montana secretary of state;

(d) a copy of the most recent fiscal yearend audited financial statement of the pharmacy benefit manager;

(e) a list of all health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(f) a description of the projected number of enrollees and injured workers to be administered by the pharmacy benefit manager in this state on an annual basis for each health carrier client, plan sponsor client, and workers' compensation insurance carrier client;

(g) a copy of the policies and procedures that demonstrate the pharmacy benefit manager has

established processes to comply with the requirements of 33-22-170 through 33-22-177 and 33-22-180 concerning maximum allowable costs lists, including the appeals process required under 33-22-173;

(h) a description of the pharmacy benefit manager's network service areas and pharmacy accessibility in this state;

(i) disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary in a pharmacy or mail-order pharmacy that is part of the pharmacy benefit manager's network; and

(j) disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary by a health carrier or workers' compensation insurance carrier in the pharmacy benefit manager or by the pharmacy benefit manager in a health carrier or workers' compensation insurance carrier.

(4) Each application for licensure must be accompanied by a nonrefundable fee of $1,000.

(5) The commissioner may require additional information for submission from an applicant and may obtain any document or information reasonably necessary to verify the information contained in an application.

(6) The commissioner may refuse to issue or renew a license if the commissioner finds that the applicant:

(a) is not competent, trustworthy, or financially responsible;

(b) has violated the insurance laws of this state, including violation of 33-22-170 through 33-22-177 and 33-22-180, or any other state; or

(c) has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

(7) The commissioner shall grant or deny an initial application for a license within 60 days from the date that a completed application and license fee is received.

(8) (a) Unless surrendered, suspended, or revoked by the commissioner, a license issued under this section is valid as long as the pharmacy benefit manager:

(i) continues to do business in this state;

(ii) remains in compliance with the provisions of [sections 1 through 12];

(iii) completes a renewal application on a form prescribed by the commissioner; and

(iv) pays an annual license renewal fee of $500.

(b) The renewal fee and application must be received by the commissioner at least 30 days before the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

(9) Denial of an application for initial licensure or renewal of licensure is considered a contested case under the Montana Administrative Procedure Act.

(10) In lieu of denying an application for initial licensure or renewal of licensure, the commissioner may allow the pharmacy benefit manager to submit a corrective action plan to cure or correct the deficiencies identified in review of the application.

Section 4. Pharmacy benefit manager prohibited practices. (1) In any participation contracts between a pharmacy benefit manager and pharmacies or pharmacists providing prescription drug coverage, a pharmacy or pharmacist may not be prohibited, restricted, or penalized in any way from disclosing to any enrollee or injured worker any information the pharmacy or pharmacist considers appropriate regarding:

(a) the decision of utilization reviewers or similar persons to authorize or deny drug coverage or benefits; and

(b) the process that is used to authorize or deny drug coverage or benefits.

(2) (a) A pharmacy benefit manager contract with a participating pharmacy or pharmacist in this state may not prohibit, restrict, or limit disclosure of information to the commissioner when the commissioner is investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements of [sections 1 through 12].

(b) A pharmacy benefit manager may not terminate the contract of or penalize a pharmacy or pharmacist for sharing any portion of the pharmacy benefit manager contract with the commissioner for investigation of a complaint or a question regarding whether the contract complies with this part.

(c) Any examination or review under this section must follow the examination procedures and requirements applicable to insurers under Title 33, chapter 1, part 4, including but not limited to the confidentiality provisions of 33-1-409.

Section 5. Marketing and advertising. (1) A pharmacy benefit manager may not cause or knowingly permit the use of an advertisement, promotion, solicitation, representation, proposal, or offer that is untrue,

deceptive, or misleading.

(2) The commissioner may not review or approve a pharmacy benefit manager's marketing or advertising documents prior to use by the pharmacy benefit manager.

(3) The commissioner shall review complaints related to pharmacy benefit manager marketing and advertising material to determine whether the materials violate the provisions of this section.

Section 6. Pharmacy benefit manager transparency to carriers and plan sponsors. (1) Beginning in the second quarter after the effective date of a contract between a pharmacy benefit manager and a health carrier, plan sponsor, or workers' compensation insurance carrier, the pharmacy benefit manager shall disclose, within 45 days of a request of the health carrier, plan sponsor, or workers' compensation insurance carrier, the following information regarding prescription drug benefits specific to the health carrier, ~~or~~ plan sponsor, or workers' compensation insurance carrier:

(a) the aggregate wholesale acquisition costs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs;

(b) the aggregate wholesale acquisition costs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs available to enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation insurance carrier;

(c) the aggregate amount of rebates received by the pharmacy benefit manager by therapeutic category of prescription drugs;

(d) any other fees received from a manufacturer or wholesale distributor and the reason for the fees;

(e) whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a manufacturer to exclusively dispense or provide a drug to enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, and the application of all consideration or economic benefits collected or received pursuant to the arrangement;

(f) prescription drug utilization information for enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, including but not limited to:

(i) the top 10 prescription drugs by average total spending for each enrollee or injured worker;

(ii) the top 10 prescription drugs by average out-of-pocket spending for each enrollee or injured worker;

(iii) the top 10 therapeutic classes of prescription drugs by total spending and volume;

(iv) the total number of pharmacy transactions; and

(v) the total number of rejected pharmacy transactions, including a breakdown of the number rejected for the following reasons:

(A) nonformulary status;

(B) prior authorization requirements; and

(C) step therapy requirements;

(g) deidentified claims-level information in electronic format that allows the health carrier, plan sponsor, or workers' compensation insurance carrier to sort and analyze the following information for each claim:

(i) whether the claim required prior authorization;

(ii) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;

(iii) any spread between the net amount paid to the pharmacy as described in subsection (1)(g)(ii) and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier;

(iv) whether the pharmacy is or is not:

(A) under common control or ownership with the pharmacy benefit manager;

(B) a preferred pharmacy for the health benefit plan or workers' compensation insurance carrier; or

(C) a mail-order pharmacy; and

(v) whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy;

(h) the aggregate amount of payments made by the pharmacy benefit manager on behalf of the health carrier, plan sponsor, or workers' compensation insurance carrier to:

(i) pharmacies owned or controlled by the pharmacy benefit manager; and

(ii) pharmacies not owned or controlled by the pharmacy benefit manager; and

(i) the aggregate amount of the fees imposed on or collected from network pharmacies or other assessments against network pharmacies, including point-of-sale fees and retroactive charges, and the amount of fees passed on to the health carrier, plan sponsor, or workers' compensation insurance carrier pursuant to

the contract with the health carrier, plan sponsor, or workers' compensation insurance carrier.

(2) A health carrier, plan sponsor, or workers' compensation insurance carrier may request more detailed data from the pharmacy manager for any aggregate data provided under this section, including information to verify the pharmacy benefit manager's source of and reported amounts of rebates and fees.

(3) A pharmacy benefit manager may require a health carrier, plan sponsor, or workers' compensation insurance carrier to agree to a nondisclosure agreement that specifies that the information reported under this section is proprietary information. A pharmacy benefit manager requiring the use of a nondisclosure agreement is not required to disclose information under this section to the health carrier, plan sponsor, or workers' compensation insurance carrier until the health carrier, plan sponsor, or workers' compensation insurance carrier has executed the nondisclosure agreement.

Section 7. Transparency report to the commissioner. (1) By July 1 each year for the immediately preceding calendar year, each pharmacy benefit manager doing business in this state shall report to the commissioner on a form prescribed by the commissioner the following information regarding prescription drug benefits provided to enrollees of each health carrier and plan sponsor and injured workers of workers' compensation insurance carriers in the state with which the pharmacy benefit manager has contracted during the previous calendar year:

(a) the aggregate prescription drug spending for all of the pharmacy benefit manager's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(b) the aggregate prescription drug spending as described in subsection (1)(a) net of all rebates and other fees and payments, direct or indirect, from all sources;

(c) the aggregate dollar amount of all rebates that the pharmacy benefit manager received from all manufacturers for all health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(d) the aggregate dollar amount of all fees from all sources, direct or indirect, that the pharmacy benefit manager received for all of the pharmacy benefit manager's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state and the reason for the fees;

(e) the aggregate dollar amount of all retained rebates and fees, as listed in subsection (1)(d), that the

pharmacy benefit manager received from all sources, direct or indirect, that were not passed through to health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(f) the aggregate retained rebate and fees percentage;

(g) the highest, lowest, and mean aggregate retained rebate and fees percentage for all of the pharmacy benefit manager's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(h) deidentified claims-level information in electronic format that allows the commissioner to sort and analyze the following information for each claim:

(i) the drug and quantity for each prescription;

(ii) whether the claim required prior authorization;

(iii) patient cost-sharing paid on each prescription;

(iv) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy by the pharmacy benefit manager, including point-of-sale and retroactive charges;

(v) any spread between the net amount paid to the pharmacy as calculated in subsection (1)(h)(iv) and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier client;

(vi) the pharmacy used for each prescription;

(vii) whether the pharmacy is or is not:

(A) under common control or ownership with the pharmacy benefit manager;

(B) a preferred pharmacy under the health benefit plan; or

(C) a mail-order pharmacy; and

(viii) whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy; and

(i) the aggregate amount of rebates passed on by the pharmacy benefit manager to the enrollees of each health carrier and plan sponsor client in this state at the point of sale that reduced the enrollee's applicable deductible, copayment, coinsurance, or other cost-sharing amount.

(2) For the purposes of this section, the aggregate retained rebate and fee percentage must be calculated for each health carrier, plan sponsor, and workers' compensation insurance carrier for rebates and

fees received in the previous calendar year by dividing the sum total dollar amount of rebates and fees from all manufacturers for all utilization of enrollees of a health carrier or plan sponsor and injured workers of a workers' compensation insurance carrier that was not passed through to the health carrier, plan sponsor, or workers' compensation insurance carrier by the sum total dollar amount of all rebates and fees received from all sources, direct or indirect, for all enrollees of a health carrier or plan sponsor and injured workers of a workers' compensation insurance carrier.

(3) The commissioner may request more detailed information from a pharmacy benefit manager for any aggregate data reported under this section, including information to verify a pharmacy benefit manager's reported amounts of rebates and fees and their allocation to a health carrier, plan sponsor, or workers' compensation insurance carrier.

(4) On the request of a pharmacy benefit manager, the commissioner may exempt from disclosure any part of the pharmacy benefit manager's submission that the commissioner determines to contain trade secrets as defined in 30-14-402.

(5) (a) Information provided pursuant to (1)(h)(iii) through (1)(h)(v) is considered a response to an examination under Title 33, chapter 1, part 4, and is subject to the confidentiality provisions of 33-1-409. Any data, documents, materials, or other information provided pursuant to those subsections is not subject to subpoena or discovery and is not admissible in evidence in any private civil action.

(b) The commissioner may use the data, documents, materials, or other information in the furtherance of a regulatory or legal action brought as part of the commissioner's official duties.

(6) (a) By December 31 of each year, the commissioner shall publish on the commissioner's website an aggregated rebate and fee transparency report based on the information submitted by each pharmacy benefit manager.

(b) The report may not contain information considered under this section to be confidential or a trade secret.

(c) The report must be published in a manner that does not disclose:

(i) the identity of a specific health carrier, plan sponsor, or workers' compensation insurance carrier;

(ii) the prices charged for a specific prescription drug or class of drugs; or

(iii) the amount of any rebates provided for a specific prescription drug or class of drugs.

(7) The commissioner may request the information required under this section at any time if the commissioner believes the information is reasonably necessary to ensure compliance with [sections 1 through 12].

Section 8. Pharmacy benefit manager appeals report. (1) Pharmacy benefit managers shall track, monitor, and report to the commissioner each quarter the following aggregated information related to appeals filed pursuant to 33-22-173:

(a) the number of appeals filed by pharmacies;

(b) whether the appeals were denied or upheld by the pharmacy benefit manager and if denied, the reasons for the denials;

(c) for each denial, confirmation that the pharmacy benefit manager provided the pharmacy in writing the pricing and other information required under 33-22-173;

(d) the total amount of price adjustments made by the pharmacy benefit manager; and

(e) the average amount of days taken to make price adjustments.

(2) The report must be filed within 30 days of the close of each calendar quarter.

(3) The commissioner may request information required under this section at any time if the commissioner believes the information is reasonably necessary to ensure compliance with [sections 1 through 12], 33-22-170 through 33-22-177, and 33-22-180.

Section 9. Network adequacy. (1) A pharmacy benefit manager shall provide an adequate and accessible pharmacy network for the provision of prescription drugs to ensure reasonable proximity of pharmacies to the businesses or personal residences of enrollees and injured workers.

(2) In determining whether a pharmacy benefit manager has complied with the requirements of this section, consideration must be given to the relative availability of physical pharmacies in a geographic area.

(3) The commissioner shall adopt rules for network adequacy.

Section 10. Federal 340B drug pricing program. A pharmacy benefit manager or health carrier may not:

(1) prohibit a federally certified health entity or a pharmacy under contract with an entity to provide pharmacy services from participating in the pharmacy benefit manager's or health carrier's provider network;

(2) reimburse a federally certified health entity or a pharmacy under contract with an entity differently than it reimburses other similarly situated pharmacies;

(3) require a claim for a drug to include a modifier to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by the medicaid program provided for in Title 53, chapter 6, part 1; or

(4) create a restriction or an additional charge on a patient who chooses to receive drugs from a federally certified health entity or a pharmacy under contract with an entity, including but not limited to a patient's inability to fully pay a copayment.

Section 11. Enforcement -- penalties. (1) The commissioner shall enforce the provisions of [sections 1 through 12], 33-22-170 through 33-22-177, and 33-22-180 and may examine the affairs of a pharmacy benefit manager to determine compliance with the provisions.

(2) Any examination under this section must follow the examination procedures and requirements applicable to insurers under Title 33, chapter 1, part 4, including the confidentiality provisions of 33-1-409.

(3) A pharmacy benefit manager may not be regularly examined under the same time period as required of insurers under 33-1-401 but the commissioner may examine the pharmacy benefit manager at any time if the commissioner believes it is reasonably necessary to ensure compliance with [sections 1 through 12].

(4) The commissioner may impose a fine in accordance with 33-1-317 and 33-1-318 for a violation of [sections 1 through 12], 33-22-170 through 33-22-177, and 33-22-180.

Section 12. Rulemaking. The commissioner may adopt rules as necessary to implement the provisions of [sections 1 through 12].

Section 13. Section 33-17-102, MCA, is amended to read:

"**33-17-102. Definitions.** As used in this chapter, the following definitions apply:

(1) (a) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for a fee or commission investigates and

negotiates the settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer.

(b) The term does not include a:

(i) licensed attorney who is qualified to practice law in this state;

(ii) salaried employee of an insurer or of a managing general agent;

(iii) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer;

(iv) licensed third-party administrator who adjusts or assists in adjustment of losses arising under policies issued by the insurer; or

(v) claims examiner as defined in 39-71-116.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster or a public adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on these coverages.

(b) The term does not include:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by the insurer in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a pharmacy benefit manager as defined in [section 2] that is licensed pursuant to [section 3];

~~(iv)~~(v) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

~~(v)~~(vi) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

~~(vi)~~(vii) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of

the trust;

~~(vii)~~(viii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

~~(viii)~~(ix) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

~~(ix)~~(x) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

~~(x)~~(xi) a company that issues credit cards and that advances for and collects premiums or charges from the company's credit card holders who have authorized the company to do so, if the company does not adjust or settle claims;

~~(xi)~~(xii) a person who adjusts or settles claims in the normal course of the person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities; or

~~(xii)~~(xiii) a person appointed as a managing general agent in this state whose activities are limited exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(4) (a) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(b) The term does not include an individual.

(5) "Consultant" means an individual who for a fee examines, appraises, reviews, evaluates, makes recommendations, or gives advice regarding an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes an individual to act as an insurance consultant.

(7) "Exchange" means a health benefit exchange established by the state of Montana or an exchange established by the United States department of health and human services in accordance with 42 U.S.C. 18031.

(8) "Home state" means the District of Columbia or any state or territory of the United States in which a person licensed under this chapter maintains a principal place of residence or a principal place of business.

(9) "Individual" means a natural person.

(10) "Insurance producer", except as provided in 33-17-103, means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(11) "Lapse" means the expiration of the license for failure to renew by the biennial renewal date.

(12) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(13) "Limited line credit insurance" includes credit life insurance, credit disability insurance, credit property insurance, credit unemployment insurance, involuntary unemployment insurance, mortgage life insurance, mortgage guaranty insurance, mortgage disability insurance, gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing the credit obligation and that the commissioner determines should be designated as a form of limited line credit insurance.

(14) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(15) "Limited lines insurance" means those lines of insurance that the commissioner finds necessary to recognize for the purposes of complying with 33-17-401(3).

(16) "Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.

(17) "Lines of authority" means any kind of insurance as defined in Title 33.

(18) "Navigator" means a person certified by the commissioner under 33-17-241 and selected to perform the activities and duties identified in 42 U.S.C. 18031, et seq.

(19) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract if the person engaged in negotiation either sells insurance or obtains insurance from insurers for purchasers.

(20) "Person" means an individual or a business entity.

(21) (a) "Public adjuster" means an adjuster retained by and representing the interests of the insured.

(b) The term does not include a person who provides an estimate of work to an insurer on behalf of an insured as long as the insured is notified of all communications between the person and the insurer related to the estimates.

(22) "Sell" means to exchange a contract of insurance by any means, for money or the equivalent, on behalf of an insurance company.

(23) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance.

(24) "Suspend" means to bar the use of a person's license for a period of time."

Section 14. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-138, 33-22-140, 33-22-141, 33-22-142, 33-22-153, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) (a) Sections 33-22-137, 33-22-150 through 33-22-152, 33-22-170 through 33-22-177, 33-22-180, and 33-22-301 apply to group or blanket policies.

(b) Sections ~~33-22-175~~ [1 through 12] and 33-22-170 through 33-22-177 apply to workers' compensation~~, group, and blanket~~ policies."

Section 15. 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) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

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

(5) "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) "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, ~~and~~ pay pharmacies or pharmacists for prescription drugs, or provide other prescription drug or device services.

(7) "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) "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.

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

(10) "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 16. Section 33-22-174, MCA, is amended to read:

"**33-22-174. 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 prescription or service as provided in subsection (2) shall cooperate with any investigation and review of network adequacy."

Section 17. Section 33-30-102, MCA, is amended to read:

"**33-30-102. Application of chapter -- construction of other related laws.** (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: [33-2-714;] 33-2-1212; 33-3-307; 33-3-308; 33-3-401; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, parts 13, 19, and 23, and [sections 1 through 12]; Title 33, chapter 3, part 6; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 10, 12, 15, 18, 19, 22, and 32, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail. (Bracketed reference in subsection (1) to 33-2-714 terminates June 30, 2025, on occurrence of contingency--sec. 48, Ch. 415, L. 2019.)"

Section 18. Section 33-31-111, MCA, is amended to read:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, parts 7 and 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Other chapters and provisions of this title apply to health maintenance organizations as follows: Title 33, chapter 1, parts 6, 12, and 13~~,~~; 33-2-1114~~,~~; 33-2-1211~~,~~ and 33-2-1212~~,~~; Title 33, chapter 2, parts 13, 19, and 23, and [sections 1 through 12]~~,~~; 33-3-401~~,~~; 33-3-422~~,~~; 33-3-431~~,~~; Title 33, chapter 3, part 6~~,~~; Title 33, chapter 10~~,~~; Title 33, chapter 12~~,~~; 33-15-308~~,~~; Title 33, chapter 17~~,~~; Title 33, chapter 19~~,~~; 33-22-107~~,~~; 33-22-129~~,~~; 33-22-131~~,~~; 33-22-136~~, 33-22-137~~, ~~33-22-138,~~ through 33-22-139~~,~~; 33-22-141~~,~~ and 33-22-142~~,~~; 33-22-152~~,~~ and 33-22-153~~,~~; 33-22-156 through 33-22-159~~,~~; 33-22-180~~,~~; 33-22-244~~,~~; 33-22-246~~,~~ and 33-22-247~~,~~; 33-22-514~~,~~ and 33-22-515~~,~~; 33-22-521~~,~~; 33-22-523~~,~~ and 33-22-524~~,~~; 33-22-526~~,~~; and Title 33, chapter 32~~, apply to health maintenance organizations~~."

Section 19. Section 33-35-306, MCA, is amended to read:

"**33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) Title 33, chapter 2, part 23, and [sections 1 through 12];

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, and 33-22-153; and

(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 20. Section 33-38-102, MCA, is amended to read:

"**33-38-102. Definitions.** As used in this part, unless the context indicates otherwise, the following definitions apply:

(1) (a) "Administrator" has the meaning provided for in 33-17-102(3).

(b) The term includes a pharmacy benefit manager as defined in [section 2].

(2) "Enroller" means a person who:

(a) solicits the purchase or renewal of a medical care discount card through that person;

(b) transmits, for consideration, from a supplier to another person or from another person to a supplier a contract or application for a medical care discount card or the renewal of a medical care discount card; or

(c) acts or aids in another manner in the delivery or negotiation of a medical care discount card or the renewal or continuance of a medical care discount card.

(3) "Health care provider" means:

(a) an individual licensed by the department of labor and industry to practice or who holds a temporary permit to practice a branch of the healing arts;

(b) a professional corporation organized pursuant to Title 35, chapter 4, by one or more individuals described in subsection (3)(a);

(c) a Montana limited liability company organized pursuant to Title 35, chapter 8, for the purpose of rendering professional services by individuals described in subsection (3)(a);

(d) a partnership of individuals described in subsection (3)(a);

(e) a Montana nonprofit corporation organized pursuant to Title 35, chapter 2, for the purpose of rendering professional health care services by one or more individuals described in subsection (3)(a); or

(f) a health care facility as defined in 50-5-101.

(4) "Health insurance issuer" means a health insurance issuer, as defined in 33-22-140, that is authorized to do business in this state and its affiliates, as defined in 33-2-1101.

(5) (a) "Medical care discount card" means a paper or plastic device or other mechanism, arrangement, account, or other device that does not constitute insurance, as defined in 33-1-201, that purports to grant, for consideration, a discount or access to a discount in a medical care-related purchase from a health

care provider.

(b) The term does not include a pharmacy discount card unless a pharmacy discount benefit is combined with another type of medical care discount.

(6) "Medical care discount card supplier" means a person engaged in selling or furnishing, either as principal or agent, for consideration, one or more medical care discount cards to another person or persons.

(7) "Network of health care providers" means two or more health care providers who are contractually obligated to provide services in accordance with the terms and conditions applicable to a medical care discount card.

(8) "Pharmacy discount card" means a paper or plastic device or other mechanism, arrangement, account, or other device that does not constitute insurance, as defined in 33-1-201, that purports to grant, for consideration, a discount or access to a discount on one or more prescription drugs, and that is not combined with another type of medical care discount.

(9) "Pharmacy discount card supplier" means a person engaged in selling or furnishing, either as a principal or agent, for consideration, one or more pharmacy discount cards to another person or persons.

(10) "Preferred provider organization company" means a company that contracts with health care providers for lower fees than those customarily charged by the health care provider for services and contracts with health insurance issuers, administrators, or self-insured employers to provide access to those lower fees to a particular group of insureds, subscribers, participants, beneficiaries, members, or claimants.

(11) "Prescription drug provider" means a pharmacy or other business that is contractually bound to provide a discount on one or more prescription drugs in conjunction with the use of a pharmacy discount card.

(12) "Service area" means the area within a 60-mile radius of the home or place of business of a medical care discount card user or pharmacy discount card user."

Section 21. Section 39-71-2375, MCA, is amended to read:

"**39-71-2375. Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements.** (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state

and the provisions of Title 39, chapter 71, part 23.

(2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.

(d) The state fund is subject to the provisions of [sections 1 through 12] if it contracts with one or more pharmacy benefit managers as defined in [section 2].

(3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory

implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312."

Section 22. Transition. A pharmacy benefit manager that is registered as an administrator under Title 33, chapter 17, part 6, and that is subject to the requirements of [sections 1 through 12] on [the date of passage and approval of this act] shall maintain the registration status under Title 33, chapter 17, part 6, until [the effective date of this act]. On licensure by the commissioner of a pharmacy benefit manager under [sections 1 through 12], the license replaces and supersedes a pharmacy benefit manager’s registration under Title 33, chapter 17, part 6.

Section 23. Codification instruction. [Sections 1 through 12] are intended to be codified as an integral part of Title 33, chapter 2, and the provisions of Title 33, chapter 2, apply to [sections 1 through 12].

Section 24. Severability. If a part of [this act] is invalid, all valid parts that are severable from the

invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 25. Effective dates. (1) Except as provided in subsection (2), [this act] is effective January 1, 2022.

(2) [Section 10] and this section are effective on passage and approval.

Section 26. Termination. [Section 10(3)] terminates June 1, 2023.

- END -

I hereby certify that the within bill,

SB 395, originated in the Senate.

_____

Secretary of the Senate

_____

President of the Senate

Signed this _____day

of_____, 2021.

_____

Speaker of the House

Signed this _____day

of_____, 2021.

SENATE BILL NO. 395

INTRODUCED BY G. HERTZ

BY REQUEST OF THE STATE AUDITOR

AN ACT CREATING THE MONTANA PHARMACY BENEFIT MANAGER OVERSIGHT ACT; ESTABLISHING LICENSURE REQUIREMENTS FOR PHARMACY BENEFIT MANAGERS; PROHIBITING CERTAIN PRACTICES; PROHIBITING UNTRUE, DECEPTIVE, OR MISLEADING ADVERTISING; REQUIRING TRANSPARENCY AND MAXIMUM ALLOWABLE COST REPORTING; PROVIDING FOR NETWORK ADEQUACY; AUTHORIZING ENFORCEMENT AND EXAMINATION AUTHORITY; EXPANDING THE MAXIMUM ALLOWABLE COST LAWS TO GROUP AND BLANKET POLICIES; PROVIDING RULEMAKING AUTHORITY; PROVIDING DEFINITIONS; AMENDING SECTIONS 33-17-102, 33-22-101, 33-22-170, 33-22-174, 33-30-102, 33-31-111, 33-35-306, 33-38-102, AND 39-71-2375, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE.