MOUNTAIN HEALTH CO-OP

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Office of Montana Commissioner of Securities and Insurance
840 Helena Ave
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RE: **Comments on Potential HB 740 Rulemaking**

The Mountain Health Co-Op ("CO-OP") offers non-profit member-governed health insurance that promotes member engagement and provides access to high quality medical care. The CO-OP contracts with RealRx, a small pharmacy benefit manager based out of Salt Lake City, Utah. The CO-OP and RealRx implemented House Bill 740 on October 1, 2025, when the bill went into effect.

The CO-OP and RealRx do not recommend rulemaking for HB 740. The bill provides enough clarity for PBMs, third party payers and health plans to implement the requirements.

1. **Does the definition of independent pharmacy outlined in House Bill 740 require additional regulatory clarification? Does the definition create the unintended inclusion of other pharmacy business models outside of similar independent or community pharmacies? Does the current definition for pharmacy benefit managers require further clarification? If so, what considerations should be made for clarity in administrative rules?**

   Pharmacies and PBMs have a single data source to use to determine qualifying pharmacies. Many use the NCPCP/Data Q data to identify independent pharmacies, but the data is based on pharmacies self-reporting their type. There are discrepancies between this data source. Rather than rulemaking, CSI could maintain the list on its website.

2. **How should "third-party payer" be further clarified in administrative rule, especially regarding self-insured employer arrangements, discount plans, and non-traditional payers?**

   No rules are required.

3. **Are there specific, objective criteria or documentation that could be required to verify a pharmacy's status as "independent" under House Bill 740, e.g. attestation forms, accreditation records, ownership documentation, affiliation disclosures? Would periodic recertification be helpful to ensure continued compliance?**

   Qualifying pharmacies could be encouraged to update self-reported data with NCPDP/Data Q as independent. That would allow a single data source for all PBMs and health plans to pull from to determine qualifying pharmacies. This would not require rulemaking.

4. **House Bill 740 mandates a minimum reimbursement floor for independent pharmacies. Is further clarity required in the form of administrative rule to define the methodology, calculation or process to update that floor? What source should the agency use when considering the Wholesale Acquisition Cost?**

   The CSI could issue a memo clarifying if PBMs and health plans should use the most recent full year CPI-U Annual Average to update the dispensing fee later than January 1 of each year, since the BLS is not usually published until mid-January.

5. **The use of maximum allowable cost (MAC) pricing and reference lists is contemplated in §33-22-172. Are there additional MAC list considerations that are not addressed in this section, such as retention and availability of MAC list & reference pricing history, additional specificity regarding accessibility of such lists, concerns regarding use of more than one MAC list or reference pricing tool, or other aspects of MAC/reference pricing?**

6. **What provisions, if any, should be established in rule for reimbursement audits and recoupments? From the perspective of pharmacy benefit managers and third-party payers, what clarifications in rule would help**

facilitate consistent application of the new fee and audit prohibitions in House Bill 740?

HB 740 does not amend current law regarding audits. Current law has been followed correctly by PBMs and health plans regarding audits.

The new recoupment language is clear and does not require rulemaking.

7. **What additional reporting requirements, if any, should PBMs, payers, or pharmacies have under the rules? Should the rules contemplate a required timeframe for advance notice of contract changes? How should any reporting requirement of the pharmacies or PBMs treat proprietary information that may be protected data?**

   PBMs are already required to submit annual reporting. No additional information from the PBM or health plan would be useful for regulators or plan members.

8. **The bill adds provisions limiting the PBM's ability to add drugs to a Maximum Allowable Cost list if they are temporarily unavailable. What length of time should constitute temporary and what source of data should the agency use in enforcing the lists?**

   Our PBM policies require the drug to be available from at least two manufacturers. This could be included in an advisory memo to encourage PBM policies to include the requirement that drugs on a MAC list must be available from multiple manufacturers. Also, MAC prices should not be placed on generic drugs.

9. **Are there existing arrangements with independent pharmacies that are jeopardized by any provisions of House Bill 740? Please indicate whether these arrangements could be addressed by rulemaking within the provisions of House Bill 740 or whether future legislative action is needed.**

   The CO-OP is always seeking innovative contract relationships to benefit members and reduce prescription drug costs. The language of HB 740 will limit the CO-OP's ability to implement some of these arrangements.

10. **What role will pharmacies/beneficiaries have in filing complaints or initiating investigations under the rule?**

Only health plan members should have standing to file complaints or initiate investigations against PBMs or health plans for compliance with HB 740.

11. **Should the rules specify periodic review or audit of compliance by the agency?**

    No rules should be established to require review or audit of compliance outside already established audits.

12. **Are the any further considerations that the agency should consider in drafting rules for House Bill 740?**

    HB 740 was passed to increase the dispensing fee to independent pharmacies. The purpose of the bill was to create a disparity between the fees given to different pharmacies.

    Under current law and practice, health plans have co-pays that apply to drugs. For the CO-OP plans, the co-pays have the same maximum amount regardless of the pharmacy. The CO-OP plans also apply a 'lesser of' pricing rule to prescription drugs to ensure members are not charged more than the actual cost of the medication. Under this approach, the plan compares the member's required cost share, such as copay or coinsurance, to the total cost of the prescription, which includes the drug ingredient cost and the pharmacy's dispensing fee. The member pays whichever amount is lower.

    For example, if the cost of the drug plus the dispensing fee was less than the co-pay, then the CO-OP member would pay the actual cost.

    - Drug A Cost: $3.00
    - Dispensing Fee: $1.50
    - Total Prescription Cost: $4.50
    - Copay: $25.00
    - Even though your copay is $25.00, you only pay $4.50 because the prescription only costs $4.50.

    If the cost of the drug plus the dispensing fee exceeds the co-pay, the CO-OP member would pay the co-pay amount. This is standard for all plans.

    - Drug A Cost: $50.00
    - Dispensing Fee: $1.50

- Total Prescription Cost: $51.50
- Copay: $25.00
- You pay your copay of $25.00

After the passage of HB 740, the actual cost of many drugs remains lower than the co-pay amount, but the member cost-share will be higher at an independent pharmacy. This was known by the independent pharmacies when they chose to support passage of the bill. Some members may choose to get their prescriptions filled at pharmacies with lower dispensing fees. The independent pharmacies chose to take that risk in exchange for a higher dispensing fee on the remaining prescriptions.

Chain Pharmacy

- Drug A Cost: $3.00
- Chain Dispensing Fee: $1.50
- Total Prescription Cost: $4.50
- Member pays $4.50

- **Independent Pharmacy**
  - Drug A Cost: $3.00
  - Independent Dispensing Fee: $15.00
  - Total Prescription Cost: $18.00
  - Member pays $18.00 at an independent pharmacy because of the increased dispensing fee.

  Health plans cannot absorb the cost difference between non-independent and independent pharmacies. Instead, health plans will choose to remove independent pharmacies from their networks in places where non-independent pharmacies exist.

Thank you for allowing the CO-OP an opportunity to comment. We look forward to working with your office to offer Montanans quality, affordable health care.

Sincerely,

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