HOUSE BILL NO. 774

INTRODUCED BY K. SEEKINS-CROWE

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATING TO DRUGS; PROHIBITING DISADVANTAGING OR DISCOURAGING MEDICAID AND COMMERCIAL INSURANCE COVERAGE FOR NONOPIOID DRUGS AS PRESCRIBED; APPLYING TO MEDICAID; APPLYING TO COMMERCIAL INSURANCE; INCLUDING CERTAIN PLANS UNDER THE ACT; AND AMENDING SECTIONS 33-31-111, 33-32-106, 33-35-306, AND 53-6-1010, MCA."

WHEREAS, Montana has acted proactively to combat opioid addiction and overdose deaths from opioids; however, work remains to be done to decrease and prevent opioid addiction. Patients, especially those with risk factors for opioid misuse, addiction, and overdose, should have equal access to nonopioid drugs and prescribers should not be prevented from prescribing either a nonopioid or opioid drug; and

WHEREAS, formulary placement and utilization management barriers are used to limit prescribers and patients from accessing pain management treatment alternatives; and

THEREFORE, it is the intent of the Legislature to ensure prescribers and patients have the necessary tools available to comprehensively approach pain management by equalizing access between nonopioid and opioid prescriptions and preventing systems that disadvantage pain management prescription drugs.

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

NEW SECTION. **Section 1. Pain relief parity in medicaid.** (1) In establishing and maintaining the formulary and preferred drug list, the Montana department of public health and human services shall ensure that nonopioid drugs approved by the federal food and drug administration for the treatment or management of pain may not be disadvantaged or discouraged, with respect to medicaid coverage, for an opioid or narcotic drug for the treatment or management of pain on the formulary and preferred drug list.

(2) This section applies to a nonopioid drug immediately on approval by the federal food and drug administration for the treatment or management of pain, regardless of whether the drug has been reviewed by

the department for inclusion on the formulary and preferred drug list. This section also applies to drugs being provided under a contract between the department and any managed care organization.

(3) For the purposes of this section, the terms "disadvantaged" and "discouraged" include but are not limited to:

(a) designating a nonopioid drug as a nonpreferred drug if an opioid or narcotic drug is designated as a preferred drug; or

(b) establishing more restrictive or more extensive utilization controls, including but not limited to more restrictive or more extensive prior authorization or step therapy requirements, for a nonopioid drug than the least restrictive or extensive utilization controls applicable to an opioid or narcotic drug. Nothing in this section precludes one opioid drug from being preferred over another opioid drug or one nonopioid drug from being preferred over another nonopioid drug.

NEW SECTION. **Section 2. Pain relief parity in commercial insurance.** (1) In establishing and maintaining its formulary and preferred drug list, any commercial insurance policy, certificate, or contract that is delivered, issued for delivery, or renewed in this state, or any self-funded employee benefit plan, to the extent not preempted by federal law, must ensure that nonopioid drugs approved by the federal food and drug administration for the treatment or management of pain may not be disadvantaged or discouraged, with respect to coverage or cost sharing, for an opioid or narcotic drug for the treatment or management of pain on the formulary and preferred drug list.

(2) This section applies to a nonopioid drug immediately on approval by the federal food and drug administration for the treatment or management of pain.

(3) If any commercial insurance policy, certificate, or contract that is delivered, issued for delivery, or renewed in this state, or any self-funded employee benefit plan, to the extent not preempted by federal law, restricts coverage of a nonopioid prescription drug for the treatment or management of pain, including through utilization management policies, such as prior authorization or step therapy, the prescribing health care provider must be granted an exception to the restriction if the prescribing health care provider confirms that, based on the provider's professional judgment, the nonopioid prescription drug is appropriate for the treatment of the patient.

(4) For the purposes of this section, the terms "disadvantaged" and "discouraged" include but are not limited to:

(a) imposing more restrictive coverage criteria on a nonopioid drug than the least restrictive coverage criteria imposed on an opioid or narcotic drug;

(b) establishing more restrictive or more extensive utilization controls, including but not limited to more restrictive or more extensive prior authorization or step therapy requirements, for a nonopioid drug than the least restrictive or extensive utilization controls applicable to an opioid or narcotic drug; or

(c) if the commercial insurance policy, certificate, or contract that is delivered, issued for delivery, or renewed in this state, or any self-funded employee benefit plan, to the extent not preempted by federal law, maintains a formulary grouped into tiers for the purposes of determining cost-sharing, placing a nonopioid drug on a tier that requires a cost-sharing responsibility that exceeds the lowest cost-sharing responsibility required for an opioid or narcotic drug on the formulary.

Section 3. 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, 23, and 24; 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; 33-22-114; 33-22-128; 33-22-129; 33-22-131; 33-22-136 through 33-22-139; 33-22-141 and 33-22-142; 33-22-152 through 33-22-159; 33-22-180; [section 2]; 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; 33-22-2103; and Title 33, chapter 32."

Section 4. Section 33-32-106, MCA, is amended to read:

"**33-32-106. Disclosure of utilization review requirements -- drug benefit information.** (1) A utilization review organization shall make its current utilization review plan prepared pursuant to 33-32-103, including clinical review criteria, standards, procedures, requirements, and restrictions, readily accessible on its website to covered persons, prospective covered persons, and health care providers. The utilization review plan must be described in detail and in easily understandable language.

(2) If a utilization review organization intends to implement a new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, the entity may not implement the change until it has:

(a) notified health care providers in writing of the new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, no less than

60 days before the new or amended plan is to be implemented; and

(b) updated its website to reflect the new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, to make the information accessible to covered persons, prospective covered persons, and health care providers.

(3) A health insurance issuer or utilization review organization, as applicable, shall display on its public website current prescription drug benefit information, including formulary lists, governed under [section 2], of each prescription drug covered under the health insurance issuer's plan."

Section 5. 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, parts 23 and 24;

(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, 33-22-114, 33-22-128, 33-22-129, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, ~~and~~ 33-22-152 through 33-22-155, and [section 2];

(j) 33-22-316;

(k) 33-22-512, 33-22-515, 33-22-525, and 33-22-526;

(l) Title 33, chapter 22, parts 7 and 21; and

(m) 33-22-707.

(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 6. Section 53-6-1010, MCA, is amended to read:

"**53-6-1010. Specifications for administration of program.** (1) The department shall adopt specifications for the administration and management of the program. Specifications may include but are not limited to program objectives, accounting and handling practices, supervisory authority, and an evaluation methodology.

(2) Information disclosed by manufacturers during negotiations and all terms and conditions negotiated between the director and manufacturers and all information requested or required under the program are public information, except for information that the department determines is proprietary information.

(3) The department may use a formulary or other committee to determine preferred drug lists for department programs. The department shall include a representative of consumers on any formulary committee or committee to determine preferred drug lists for purchase by the department or reimbursement of costs. Any formulary or preferred drug list must be based on objective clinical data on safety and effectiveness. If two or more drugs are found to be equally effective and safe for the treatment of the same medical condition, the drug available at the lowest net price, inclusive of discounts and rebates, must be placed on the list. Other drugs for treating the same medical condition may be added to the list if they are therapeutically equivalent and the department determines them to be cost-effective. The requirements of this section are in addition to the requirements in [section 1].

(4) The department may negotiate rebates from the prescription drug manufacturers for drugs that will be on any preferred drug list. The department may negotiate price discounts with prescription drug manufacturers for any state-purchased health care programs, including medicaid, the state children's health insurance program, and the program provided for in 53-6-1002.

(5) The department may use the access restrictions and a preferred drug list to negotiate for the most favorable discount prices and rebates for the program.

(6) The department may participate in multistate purchasing pool initiatives for the benefit of the program."

NEW SECTION. **Section 7. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 53, chapter 6, part 10, and the provisions of Title 53, chapter 6, part 10, apply to [section 1].

(2) [Section 2] is 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 [section 2].

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