State PBM Reform Inventory

Updated October 2026

Montana

Issue	Summary	Citation
Licensing/Registration	A person may not perform an act or do business in this state as a PBM without a valid license issued under this part by the Insurance Commissioner. A PBM shall apply to the commissioner on a form prescribed by the commissioner and pay a non-refundable fee of $1,000 for an initial application and $500 for renewal. By statute, an applicant must provide: • A copy of the most recent fiscal year-end audited financial statement; • A list of all health carriers, plan sponsors, and workers' compensation insurance carrier clients in Montana; • A description of the projected number of enrollees and injured workers to be administered by the PBM in this state on an annual basis for each health carrier client, plan sponsor client, and workers' compensation insurance carrier client; • A copy of the policies and procedures that demonstrate the PBM has established processes to comply with the requirements related to MAC lists. • A description of the PBM's network service areas and pharmacy accessibility in this state; • 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 PBM's network; and • 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 PBM or by the PBM in a health carrier	Mont. Code Ann.§ 33-2-2403
Reporting Requirements	Beginning in the second quarter after the effective date of a contract between a PBM and a health carrier, plan sponsor, or workers' compensation insurance carrier, the PBM shall disclose, within 45 days of a request, the following information regarding prescription drug benefits specific to the health	Mont. Code Ann. § 33-2-2406;

	carrier, plan sponsor, or workers' compensation insurance carrier:
	• The aggregate WACs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs;
	• The aggregate WACs 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;
	• The aggregate amount of rebates received by the PBM by therapeutic category of prescription drugs;
	• Any other fees received from a manufacturer or wholesale distributor and the reason for the fees;
	• Whether the PBM 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;
	• Prescription drug utilization information for enrollers of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, including but not limited to:
	  ○ The top 10 prescription drugs by average total spending for each enrollee or injured worker;
	  ○ The top 10 prescription drugs by average out-of-pocket spending for each enrollee or injured worker;
	  ○ The top 10 therapeutic classes of prescription drugs by total spending and volume;
	  ○ The total number of pharmacy transactions; and
	  ○ The total number of rejected pharmacy transactions, including a breakdown of the number rejected for the following reasons:
	  ▪ Nonformulary status;
	  ▪ Prior authorization requirements; and
	  ▪ Step therapy requirements;
	• De-identified 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:
	  ○ Whether the claim required prior authorization;
		Mont. Code Ann. § 33-2-2407

	○ 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; ○ Any spread between the net amount paid to the pharmacy and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier; ○ Whether the pharmacy is or is not: ○ Under common control or ownership with the PBM; ○ A preferred pharmacy for the health benefit plan or workers' compensation insurance carrier; or ○ a mail-order pharmacy; and ○ Whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy; • The aggregate amount of payments made by the PBM on behalf of the health carrier, plan sponsor, or workers' compensation insurance carrier to: ○ Pharmacies owned or controlled by the PBM; and ○ Pharmacies not owned or controlled by the PBM; and • 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. By July 1 each year, each PBM 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, plan sponsor, and injured workers of workers' compensation insurance carriers in the state with which the PBM has contracted during the previous calendar year: • The aggregate prescription drug spending for all of the PBM's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;	

	• The aggregate prescription drug spending net of all rebates and other fees and payments, direct or indirect, from all sources;
	• The aggregate dollar amount of all rebates that the PBM received from all manufacturers;
	• The aggregate dollar amount of all fees from all sources, direct or indirect, that the PBM received and the reason for the fees;
	• The aggregate dollar amount of all retained rebates and fees that were not passed through to clients;
	• The aggregate retained rebate and fees percentage;
	• The highest, lowest, and mean aggregate retained rebate and fees percentage for all of the PBM's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;
	• De-identified claims-level information in electronic format that allows the commissioner to sort and analyze the following information for each claim:
	  ○ The drug and quantity for each prescription;
	  ○ Whether the claim required prior authorization;
	  ○ Patient cost-sharing paid on each prescription;
	  ○ 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 PBM, including point-of- sale and retroactive charges;
	  ○ Any spread between the net amount paid to the pharmacy and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier client;
	  ○ The pharmacy used for each prescription;
	  ○ Whether the pharmacy is or is not:
	  ▪ Under common control or ownership with the PBM;
	  ▪ A preferred pharmacy under the health benefit plan; or
	  ▪ A mail-order pharmacy; and
	  ○ Whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy; and
	• The aggregate amount of rebates passed on by the PBM to the enrollers 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.	
PBM Income	N/A	

Pharmacy Contracting	**MAC Pricing:**
	Before a PBM places or continues a drug on a MAC list, the drug:
	• 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;
	• Must be available for purchase by pharmacies in this state from national or regional wholesalers; and
	• May not be obsolete, temporarily unavailable, or listed on a drug shortage list.
	
	Note: the phrase "temporarily unavailable or listed on a drug shortage list" expires on June 30, 2029.
	
	At the time of entering into a contract with a pharmacy or a PSAO and subsequently upon request, a plan sponsor, health insurance issuer, or PBM shall provide the pharmacy or PSAO with the sources used to determine the pricing for the MAC list or the reference used for reference pricing.
	• If using a MAC list, the plan sponsor, health insurance issuer, or PBM shall:
	  ○ Review and update the price information for each drug on the MAC list at least once every 10 calendar days to reflect any modification of pricing, ensuring that MAC increases are processed and updated on the same schedule as decreases;
	  ○ Establish a process for eliminating products from the MAC list or modifying the prices in the MAC list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and
	  ○ Provide a process for each pharmacy to readily access the MAC list specific to the pharmacy in a searchable and usable format.
	• If using reference pricing, a plan sponsor, health insurance issuer, or PBM shall:
		Mont. Code Ann. § 33-22-171;
		
		Mont. Code Ann. § 33-22-172;
		
		Mont. Code Ann. § 33-22-173;
		
		Mont. Code Ann. § 33-22-177

	○ Review and update not less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used, updating reference pricing on the same date as the change in the referenced source; and ○ Provide a process for each pharmacy to readily access the reference pricing specific to the plan sponsor or the health insurance issuer's plan. • In contracting with a pharmacy or a PSAO, a plan sponsor or PBM shall: ○ Provide a procedure by which a pharmacy or a PSAO may appeal the price of a drug or drugs on the MAC list; ○ Provide a telephone number at which a network pharmacy may contact the PBM to discuss the status of the pharmacy's appeal; and ○ Respond to an appeal no later than 10 calendar days after the date the appeal is made. • If the final determination is a denial of the pharmacy's or the PSAO's appeal, the PBM shall state the reason for the denial and provide the NDC of an equivalent drug that is available for purchase by pharmacies in this state from national or regional wholesalers at a price that is equal to or less than the MAC for that drug. • If a pharmacy's or a PSAO's appeal is determined to be valid by the PBM, the PBM shall: ○ Make an adjustment in the drug price effective on the date the appeal is resolved; ○ Make the adjustment applicable to all similarly situated network pharmacy providers as determined by the plan sponsor or the PBM, as appropriate; and ○ Permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of the original claim or claims. • A PBM shall make price adjustments to all similarly situated pharmacies within 3 days. • A pharmacy or a PSAO shall file its appeal within 10 calendar days from the time of denial by the PBM. **Minimum Reimbursement:** A plan sponsor, PBM, or third-party payer shall ensure that reimbursement to independent pharmacies for each drug	

	dispensed is not less than the NADAC plus a professional dispensing fee. The NADAC price must be published in effect for the day the drug claim was billed by the pharmacy.
	• If a particular drug does not have a published national average drug acquisition price, the reimbursement to independent pharmacies must be:
	  ○ For generic drugs, 100% of published WACs plus a professional dispensing fee; and
	  ○ For brand-name drugs, 100% of WACs plus a professional dispensing fee.
	• The minimum professional dispensing fee for independent pharmacies is $15, subject to an annual increase. On January 1 of each year, a plan sponsor, PBM, or third-party payer shall increase the amount of the minimum professional dispensing fee for independent pharmacies for inflation. Inflation is measured by the annual percentage increase, if any, in the Consumer Price Index, U.S. city average, all urban consumers, for all items.
	
	Note: The NADAC reimbursement requirement in s. 22-172 expires on June 30, 2029.
	
	Patient Steering:
	A PBM may not:
	• Reimburse a network pharmacy an amount less than the contract price between the PBM and the insurer, third-party payer, or the pharmacy services management organization the PBM has contracted with; or
	• Require or coerce a patient to use a pharmacy that is owned by or affiliated with the PBM.
	
	Note: the patient steering provisions in s. 22-177 expire on June 30, 2029.	

Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A plan sponsor, health insurance issuer, or PBM may not require a pharmacist to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy. A PBM or third-party payer may not charge a patient a copayment that exceeds the cost of the prescription drug. If a	Mont. Code Ann. § 33-22-172; Mont. Code Ann. § 33-22-176;

	patient pays a copayment, the dispensing provider or pharmacy may retain the adjudicated reimbursement and the PBM or third-party payer may not alter the adjudicated reimbursement. **Copay Cap:** Each individual policy of disability insurance or certificate issued that contains coverage for prescription drugs must limit the insured's required copayment or other cost-sharing requirement to $35 for up to a 30-day supply of insulin, regardless of the amount or type of insulin prescribed. • The limitation in this section applies to insulin covered by the insurer's formulary. • Coverage of insulin prescribed for an insured is not subject to a deductible. Cost-sharing amounts paid by the insured for insulin must be counted toward the insured's deductible. • This section does not apply to disability income, hospital indemnity, Medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.	Mont. Code Ann. § 33-22-312