

Effective 5/12/2015

31A-22-640 Insurer and pharmacy benefit management services -- Registration -- Maximum allowable cost -- Audit restrictions.

- (1) For purposes of this section:
 - (a) "Maximum allowable cost" means:
 - (i) a maximum reimbursement amount for a group of pharmaceutically and therapeutically equivalent drugs; or
 - (ii) any similar reimbursement amount that is used by a pharmacy benefit manager to reimburse pharmacies for multiple source drugs.
 - (b) "Obsolete" means a product that may be listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured.
 - (c) "Pharmacy benefit manager" means a person or entity that provides pharmacy benefit management services as defined in Section 49-20-502 on behalf of an insurer as defined in Subsection 31A-22-636(1).
- (2) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy audit provisions of Section 58-17b-622.
- (3) A pharmacy benefit manager shall not use maximum allowable cost as a basis for reimbursement to a pharmacy unless:
 - (a) the drug is 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 equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and
 - (b) the drug is:
 - (i) generally available for purchase in this state from a national or regional wholesaler; and
 - (ii) not obsolete.
- (4) The maximum allowable cost may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state.
- (5) For every drug for which the pharmacy benefit manager uses maximum allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall:
 - (a) include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data;
 - (b) review and make necessary adjustments to the maximum allowable cost, using the most recent data sources identified in Subsection (5)(a), at least once per week;
 - (c) provide a process for the contracted pharmacy to appeal the maximum allowable cost in accordance with Subsection (6); and
 - (d) include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible.
- (6)
 - (a) The right to appeal in Subsection (5)(c) shall be:
 - (i) limited to 21 days following the initial claim adjudication; and
 - (ii) investigated and resolved by the pharmacy benefit manager within 14 business days.
 - (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted pharmacy with the reason for the denial and the identification of the national drug code of the drug that may be purchased by the pharmacy at a price at or below the price determined by the pharmacy benefit manager.

- (7) The contract with each pharmacy shall contain a dispute resolution mechanism in the event either party breaches the terms or conditions of the contract.
- (8)
- (a) To conduct business in the state, a pharmacy benefit manager shall register with the Division of Corporations and Commercial Code within the Department of Commerce and annually renew the registration. To register under this section, the pharmacy benefit manager shall submit an application which shall contain only the following information:
 - (i) the name of the pharmacy benefit manager;
 - (ii) the name and contact information for the registered agent for the pharmacy benefit manager; and
 - (iii) if applicable, the federal employer identification number for the pharmacy benefit manager.
 - (b) The Department of Commerce may establish a fee in accordance with Title 63J, Chapter 1, Budgetary Procedures Act, for the initial registration and the annual renewal of the registration, which may not exceed \$100 per year.
 - (c) The following entities do not have to register as a pharmacy benefit manager under Subsection (8)(a) when the entity is providing formulary services to its own patients, employees, members, or beneficiaries:
 - (i) a health care facility licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;
 - (ii) a pharmacy licensed under Title 58, Chapter 17b, Pharmacy Practice Act;
 - (iii) a health care professional licensed under Title 58, Occupations and Professions;
 - (iv) a health insurer; and
 - (v) a labor union.
- (9) This section does not apply to a pharmacy benefit manager when the pharmacy benefit manager is providing pharmacy benefit management services on behalf of the state Medicaid program.

Amended by Chapter 258, 2015 General Session