Pharmacy Benefit Amendments

2025 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Norman K Thurston

LONG TITLE

General Description:

This bill amends provisions related to health insurance pharmacy benefits.

Highlighted Provisions:

This bill:

- defines terms;
- requires the commissioner of the Insurance Department to assist in creating a form if requested;
- requires a health benefit plan to ensure pharmaceutical rebates are used for certain purposes;
- requires a pharmacy benefit manager to offer certain options to self-funded health benefit plans; and
- provides certain parameters for the Public Employees' Benefit Health Plan (PEHP) when PEHP enters into a contract with a pharmacy benefit manger.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-2-212, as last amended by Laws of Utah 2020, Chapter 32

31A-22-643, as enacted by Laws of Utah 2014, Chapter 111

31A-46-102, as last amended by Laws of Utah 2020, Chapters 198, 275 and 372

49-20-503, as last amended by Laws of Utah 2012, Chapter 265

ENACTS:

31A-46-311, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-2-212** is amended to read:

31A-2-212 . Miscellaneous duties.

(1) Upon issuance of an order limiting, suspending, or revoking a person's authority to do business in Utah, and when the commissioner begins a proceeding against an insurer under Chapter 27a, Insurer Receivership Act, the commissioner:

(a) shall notify by mail the producers of the person or insurer of whom the commissioner has record; and

(b) may publish notice of the order or proceeding in any manner the commissioner considers necessary to protect the rights of the public.

(2)(a) When required for evidence in a legal proceeding, the commissioner shall furnish a certificate of authority of a licensee to transact the business of insurance in Utah on any particular date.

(b) The court or other officer shall receive a certificate of authority described in this Subsection (2) in lieu of the commissioner's testimony.

(3)(a) On the request of an insurer authorized to do a surety business, the commissioner shall furnish a copy of the insurer's certificate of authority to a designated public officer in this state who requires that certificate of authority before accepting a bond.

(b) The public officer described in Subsection (3)(a) shall file the certificate of authority furnished under Subsection (3)(a).

(c) After a certified copy of a certificate of authority is furnished to a public officer, it is not necessary, while the certificate of authority remains effective, to attach a copy of it to any instrument of suretyship filed with that public officer.

(d) Whenever the commissioner revokes the certificate of authority or begins a proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a surety business, the commissioner shall immediately give notice of that action to each public officer who is sent a certified copy under this Subsection (3).

(4)(a) The commissioner shall immediately notify every judge and clerk of the courts of record in the state when:

(i) an authorized insurer doing a surety business:

(A) files a petition for receivership; or

(B) is in receivership; or

(ii) the commissioner has reason to believe that the authorized insurer doing surety business:

(A) is in financial difficulty; or

(B) has unreasonably failed to carry out any of the authorized insurer's contracts.

(b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the judges and clerks to notify and require a person that files with the court a bond on which the authorized insurer doing surety business is surety to immediately file a new bond with a new surety.

(5)(a) The commissioner shall require an insurer that issues, sells, renews, or offers health insurance coverage in this state to comply with PPACA and administrative rules adopted by the commissioner related to regulation of health benefit plans, including:

(i) lifetime and annual limits;

(ii) prohibition of rescissions;

(iii) coverage of preventive health services;

(iv) coverage for a child or dependent;

(v) pre-existing condition limitations;

(vi) insurer transparency of consumer information including plan disclosures, uniform coverage documents, and standard definitions;

(vii) premium rate reviews;

(viii) essential health benefits;

(ix) provider choice;

(x) waiting periods;

(xi) appeals processes;

(xii) rating restrictions;

(xiii) uniform applications and notice provisions;

(xiv) certification and regulation of qualified health plans; and

(xv) network adequacy standards.

(b) The commissioner shall preserve state control over:

(i) the health insurance market in the state;

(ii) qualified health plans offered in the state; and

(iii) the conduct of navigators, producers, and in-person assisters operating in the state.

(6) If requested by an association that represents pharmacies or pharmacists, the commissioner shall assist the association in developing a form that outlines a pharmacy's rights under state and federal law related to pharmacy benefits, pharmacy benefit managers, and health benefit plans.

Section 2. Section **31A-22-643** is amended to read:

31A-22-643 . Prescription synchronization -- Copay and dispensing fee restrictions -- Rebate requirements -- Pharmacy networks.

(1) For purposes of this section:

(a) "Administrative fee" means the same as that term is defined in Section 31A-46-102.

(b) "Copay" means the copay normally charged for a prescription drug.

[~~(b)~~] (c) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).

[~~(c)~~] (d) "Network pharmacy" means a pharmacy included in a health insurance plan's network of pharmacy providers.

(e) "Pharmacy benefit manager" means the same as that term is defined in Section 31A-46-102.

[~~(d)~~] (f) "Prescription drug" means a prescription drug, as defined in Section 58-17b-102, that is prescribed for a chronic condition.

(g) "Rebate" means the same as that term is defined in Section 31A-46-102.

(h) "Standard rebate amount" means a rebate amount that:

(i) is estimated and set by a health benefit plan for a drug product;

(ii) adjusts each quarter based on rebate underpayments or overpayments; and

(iii) is applied when the drug product is dispensed.

(2) A health insurance plan may not charge an amount in excess of the copay for the dispensing of a prescription drug in a quantity less than the prescribed amount if:

(a) the pharmacy dispenses the prescription drug in accordance with the health insurer's synchronization policy; and

(b) the prescription drug is dispensed by a network pharmacy.

(3) A health insurance plan that includes a prescription drug benefit:

(a) shall implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees; and

(b) may not base the dispensing fee for an individual prescription on the quantity of the prescription drug dispensed to fill or refill the prescription unless otherwise agreed to by the plan and the contracted pharmacy at the time the individual requests synchronization.

(4) [~~This section applies to health benefit plans renewed or entered into on or after January 1, 2015.~~]

(a) A health benefit plan ensure that each pharmaceutical manufacturer rebate is used exclusively to benefit enrollees using one or multiple of the following methods:

(i) passing down the rebate to the point of sale to offset an enrollee's deductible or

coinsurance;

(ii) using the rebate to reduce premiums paid by the enrollee; or

(iii) using the rebate to enhance enrollee health benefits.

(b) When passing down a rebate as described in Subsection (4)(a)(i), a health benefit plan may:

(i) divide the rebate between the health benefit plan and the enrollee in a manner that is proportional to the enrollee's payment obligation; or

(ii) use a standard rebate amount.

(5) A health benefit plan may not prohibit or condition participation in one pharmacy network on participation in another pharmacy network.

(6) Subsections (4) and (5) apply to a health benefit plan renewed or entered into on or after July 1, 2026.

Section 3. Section **31A-46-102** is amended to read:

31A-46-102 . Definitions.

As used in this chapter:

(1) "340B drug" means a drug purchased through the 340B drug discount program by a 340B entity.

(2) "340B drug discount program" means the 340B drug discount program described in 42 U.S.C. Sec. 256b.

(3) "340B entity" means:

(a) an entity participating in the 340B drug discount program;

(b) a pharmacy of an entity participating in the 340B drug discount program; or

(c) a pharmacy contracting with an entity participating in the 340B drug discount program to dispense drugs purchased through the 340B drug discount program.

(4) "Administrative fee" means any payment, other than a rebate, that a pharmaceutical manufacturer makes directly or indirectly to a pharmacy benefit manager.

(5) "Allowable claim amount" means the amount paid by an insurer under the customer's health benefit plan.

(6) "Contracting insurer" means an insurer with whom a pharmacy benefit manager contracts to provide a pharmacy benefit management service.

(7) "Cost share" means the amount paid by an insured customer under the customer's health benefit plan.

[~~(8) "Device" means the same as that term is defined in Section 58-17b-102.~~]

[~~(9)~~] (8) "Direct or indirect remuneration" means any adjustment in the total compensation:

(a) received by a pharmacy from a pharmacy benefit manager for the sale of a drug, device, or other product or service; and

(b) that is determined after the sale of the product or service.

[~~(10)~~] (9) "Dispense" means the same as that term is defined in Section 58-17b-102.

[~~(11)~~] (10) "Drug" means the same as that term is defined in Section 58-17b-102.

[~~(12)~~] (11) "Insurer" means the same as that term is defined in Section 31A-22-636.

[~~(13)~~] (12) "Maximum allowable cost" means:

(a) a maximum reimbursement amount for a group of pharmaceutically and therapeutically equivalent drugs; or

(b) any similar reimbursement amount that is used by a pharmacy benefit manager to reimburse pharmacies for multiple source drugs.

[~~(14)~~] (13) "Medicaid program" means the same as that term is defined in Section 26B-3-101.

[~~(15)~~] (14) "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.

[~~(16)~~] (15) "Patient counseling" means the same as that term is defined in Section 58-17b-102.

[~~(17)~~] (16) "Pharmaceutical facility" means the same as that term is defined in Section 58-17b-102.

[~~(18)~~] (17) "Pharmaceutical manufacturer" means a pharmaceutical facility that manufactures prescription drugs.

[~~(19)~~] (18) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

[~~(20)~~] (19) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(21)~~] (20) "Pharmacy benefits management service" means any of the following services provided to a health benefit plan, or to a participant of a health benefit plan:

(a) negotiating the amount to be paid by a health benefit plan for a prescription drug; or

(b) administering or managing a prescription drug benefit provided by the health benefit plan for the benefit of a participant of the health benefit plan, including administering or managing:

(i) an out-of-state mail service pharmacy;

(ii) a specialty pharmacy;

(iii) claims processing;

(iv) payment of a claim;

(v) retail network management;

(vi) clinical formulary development;

(vii) clinical formulary management services;

(viii) rebate contracting;

(ix) rebate administration;

(x) a participant compliance program;

(xi) a therapeutic intervention program;

(xii) a disease management program; or

(xiii) a service that is similar to, or related to, a service described in Subsection [~~(21)(a) or (21)(b)(i) through (xii).~~] (20)(a) or this Subsection (20)(b).

[~~(22)~~] (21) "Pharmacy benefit manager" means a person licensed under this chapter to provide a pharmacy benefits management service.

[~~(23)~~] (22) "Pharmacy service" means a product, good, or service provided to an individual by a pharmacy or pharmacist.

[~~(24)~~] (23) "Pharmacy services administration organization" means an entity that contracts with a pharmacy to assist with third-party payer interactions and administrative services related to third-party payer interactions, including:

(a) contracting with a pharmacy benefit manager on behalf of the pharmacy; and

(b) managing a pharmacy's claims payments from third-party payers.

[~~(25)~~] (24) "Pharmacy service entity" means:

(a) a pharmacy services administration organization; or

(b) a pharmacy benefit manager.

[~~(26)~~] (25) "Prescription device" means the same as that term is defined in Section 58-17b-102.

[~~(27)~~] (26) "Prescription drug" means the same as that term is defined in Section 58-17b-102.

[~~(28)~~] (27)(a) "Rebate" means a refund, discount, or other price concession that is paid by a pharmaceutical manufacturer to a pharmacy benefit manager based on a prescription drug's utilization or effectiveness.

(b) "Rebate" does not include an administrative fee.

[~~(29)~~] (28)(a) "Reimbursement report" means a report on the adjustment in total compensation for a claim.

(b) "Reimbursement report" does not include a report on adjustments made pursuant to a pharmacy audit or reprocessing.

[~~(30)~~] (29) "Retail pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(31)~~] (30) "Sale" means a prescription drug or prescription device claim covered by a

health benefit plan.

(31) "Spread pricing" means the practice in which a pharmacy benefit manager charges a health benefit plan a different amount for pharmacist services than the amount the pharmacy benefit manager reimburses a pharmacy for pharmacist services.

(32) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C. Sec. 1395w-3a.

Section 4. Section **31A-46-311** is enacted to read:

31A-46-311 . Options for self-funded health benefit plans.

A pharmacy benefit manager shall offer to a self-funded health benefit plan, as an option for the self-funded health benefit plan's design, pharmacy benefit management services that:

(1) comply with the provisions of Subsections 31A-22-643(4) and (5), collectively and individually; and

(2) do not include spread pricing.

Section 5. Section **49-20-503** is amended to read:

49-20-503 . Request for proposals for pharmacy benefits manager for Public Employees' Benefit and Insurance Program.

(1)(a) The board shall issue a request for proposals before entering into or renewing a contract with a pharmacy benefit manager to obtain pharmacy benefits management services.

(b) When the board issues a request for proposals for a pharmacy benefits manager to provide pharmacy benefits management services for the program, the request for proposals shall:

[~~(a)~~] (i) require each responder to comply with the pharmacy audit provisions of Section 58-17b-622; and

[~~(b)~~] (ii) provide each responder with the option to include, among the billing options proposed, a billing option that complies with the requirements described in this section.

(2) The billing option described in Subsection (1)(b) shall require the pharmacy benefits manager to, on at least a monthly basis, submit to the board an invoice for all pharmacy services paid by the pharmacy benefits manager on behalf of the program since the last request for payment or reimbursement.

(3) The invoice described in Subsection (2) shall state, as a separate item from any other amount:

(a) the total amount due to the pharmacy benefits manager for all pharmacy services

billed in the invoice; and

(b) the total amount paid by the pharmacy benefits manager for the same pharmacy services for which payment is sought in that invoice.

(4) When selecting a pharmacy benefit manager, the board shall give preference to a proposal from a non-profit organization if the proposal provided by the non-profit organization would not be significantly more expensive than the otherwise lowest priced qualified proposal.

(5) The board may not renew or continue a contract with a pharmacy benefit manager that exceeds five years without issuing a request for proposals in accordance with Subsection (1).

Section 6. **Effective Date.**

This bill takes effect on May 7, 2025.