HB0272S01 compared with HB0272

~~{deleted text}~~ shows text that was in HB0272 but was deleted in HB0272S01.

inserted text shows text that was not in HB0272 but was inserted into HB0272S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative Paul Ray proposes the following substitute bill:

PHARMACY BENEFIT AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Paul Ray

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends the Insurance Code.

Highlighted Provisions:

This bill:

- renames the Pharmacy Benefit Manager Licensing Act as Pharmacy Benefits;
- requires the Insurance Department to annually publish the total value of rebates and administrative fees received by a pharmacy benefit manager from a pharmaceutical manufacturer;
- creates and amends definitions;
- prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacist's disclosure of certain information regarding a prescription device;
- prohibits a pharmacy benefit manager from requiring an insured customer from

paying more than a specified amount for a prescription device;

- prohibits a pharmacy benefit manager from reducing a pharmacy's total compensation for the sale of a drug, device, or other product or service unless the pharmacy benefit manager provides the pharmacy with at least 30 days notice;
- prohibits a pharmacy benefit manager from denying or reducing a reimbursement to a pharmacy or a pharmacist after the adjudication of a claim unless an investigation or audit proves certain behavior;
- prohibits a pharmacy benefit manager from denying or reducing a reimbursement to a pharmacy or pharmacist, after adjudication of a claim, pursuant to a performance contract;
- ~~prohibits insurers from excluding a pharmacy from a health benefit plan's provider network if the pharmacy is willing to abide by the terms and conditions of the plan;~~
- requires an insurer to notify pharmacies that they are eligible to participate in the insurer's health benefit plan on certain conditions;
- requires a health benefit plan's terms and conditions for pharmacy coverage to be applied uniformly across enrollees and pharmacies;
- prohibits a pharmacy benefit manager from entering into contracts with pharmacies in a health benefit plan's provider network unless the terms and conditions of the contracts for coverage and total compensation are identical;
- prohibits an insurer from promoting the use of one pharmacy in a provider network over another, except for the Public Employees' Benefit and Insurance Program with respect to a specialty drug;
- prohibits an insurer from requiring the use of an out-of-state mail service pharmacy as a condition for pharmacy coverage;
- ~~requires an insurer to provide the name and address of pharmacies covered by a health benefit plan to plan enrollees;~~
- prohibits an insurer from prohibiting a pharmacy from informing a customer that the pharmacy is covered by a specific health benefit plan;
- prohibits a pharmacy from waiving, discounting, or subsidizing a health benefit plan's cost sharing requirements or otherwise providing services on terms that differ from those established by the plan;

~~{~~ ▸ ~~prohibits an out-of-state mail service pharmacy from automatically filling or refilling a prescription without the patient's consent;~~

~~}~~ ▸ requires a pharmacy benefit manager to distribute ~~{unretained }~~manufacturer rebates to insurers and enrollees;

▸ prohibits a pharmacy benefit manager from contracting with a health insurer in certain instances unless the pharmacy benefit manager agrees to regularly report to the insurer detailed, claim-level information regarding pharmaceutical manufacturer rebates received by the pharmacy benefit manager in connection with the contract;~~{ and}~~

▸ requires ~~{a pharmaceutical manufacturer}~~manufacturers and insurers to report ~~{to the Legislature at least once each calendar quarter the wholesale acquisition cost of each of the manufacturer's}~~certain information on the cost of prescription drugs ~~{that are available for purchase by residents of the state}~~to the Insurance Department; and

▸ requires the Insurance Department to publish prescription drug information reported to the department.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-46-101, as enacted by Laws of Utah 2019, Chapter 241

31A-46-102, as enacted by Laws of Utah 2019, Chapter 241

31A-46-301, as enacted by Laws of Utah 2019, Chapter 241

31A-46-302, as renumbered and amended by Laws of Utah 2019, Chapter 241

31A-46-303, as renumbered and amended by Laws of Utah 2019, Chapter 241

31A-46-304, as enacted by Laws of Utah 2019, Chapter 241

ENACTS:

31A-46-305, Utah Code Annotated 1953

31A-46-306, Utah Code Annotated 1953

31A-46-307, Utah Code Annotated 1953

~~{31A-46-308}~~**31A-47-101**, Utah Code Annotated 1953

31A-47-102, Utah Code Annotated 1953

31A-47-103, Utah Code Annotated 1953

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

Section 1. Section **31A-46-101** is amended to read:

CHAPTER 46. PHARMACY BENEFITS ACT

31A-46-101. Title.

This chapter is known as [~~the~~] "Pharmacy [~~Benefit Manager Licensing Act~~] Benefits Act."

Section 2. Section **31A-46-102** is amended to read:

31A-46-102. Definitions.

As used in this chapter:

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

(2) "Contracting insurer" means an insurer [~~as defined in Section 31A-22-636~~] with whom a pharmacy benefit manager contracts to provide a pharmacy benefit management service.

(3) "Drug" means the same as that term is defined in Section 58-17b-102.

(4) "Insurer" means the same as that term is defined in Section 31A-22-636.

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

(6) "Pharmaceutical manufacturer" means a pharmaceutical facility that manufactures prescription drugs.

[~~(3)~~] (7) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

[~~(4)~~] (8) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(5)~~] (9) "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) a 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 [~~(5)~~] (9)(a) or [~~(5)~~] (9)(b)(i) through (xii).

[~~(6)~~] (10) "Pharmacy benefit manager" means a person licensed under this chapter to provide a pharmacy benefits management service.

[~~(7)~~] (11) "Pharmacy service" means a product, good, or service provided to an individual by a pharmacy or pharmacist.

(12) "Prescription device" means the same as that term is defined in Section 58-17b-102.

(13) "Prescription drug" means the same as that term is defined in Section 58-17b-102.

[~~(8)~~] (14) (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.

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

Section 3. Section **31A-46-301** is amended to read:

31A-46-301. Reporting requirements.

(1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall report to the department, for the previous calendar year:

(a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit manager had a contract;

(b) the total value, in the aggregate, of all rebates and administrative fees that are attributable to enrollees of a contracting insurer; and

(c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer.

(2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(3) (a) The department shall publish the information provided by a pharmacy benefit manager under [~~Subsection~~] Subsections (1)(b) and (1)(c) in the annual report described in Section 31A-2-201.2.

(b) The department may not publish information submitted under Subsection (1)(b) or (c) in a manner that:

(i) makes a [~~specific submission from a contracting insurer or~~] pharmacy benefit manager or contracting insurer identifiable; or

(ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2.

(c) At least 30 days before the day on which the department publishes the data, the department shall provide a pharmacy benefit manager that submitted data under Subsection (1)(b) or (c) with:

(i) a general description of the data that will be published by the department;

(ii) an opportunity to submit to the department, within a reasonable period of time and in a manner established by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(A) any correction of errors, with supporting evidence and comments; and

(B) information that demonstrates that the publication of the data will violate Subsection (3)(b), with supporting evidence and comments.

Section 4. Section **31A-46-302** is amended to read:

31A-46-302. Direct or indirect remuneration by pharmacy benefit managers -- Pharmacist disclosures -- Limit on customer payment for prescription drugs and prescription devices -- 30-day notice required to reduce total compensation.

(1) As used in this section:

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

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

(c) "Direct or indirect remuneration" means any adjustment in the total compensation:

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

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

(d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

(e) "Pharmacy reimbursement" means the amount paid to a pharmacy by a pharmacy benefit manager for a dispensed prescription drug or prescription device.

(f) "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:

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

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

(g) "Pharmacy service entity" means:

(i) a pharmacy services administration organization; or

(ii) a pharmacy benefit manager.

(h) (i) "Reimbursement report" means a report on the adjustment in total compensation for a claim.

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

(i) "Sale" means a prescription drug or prescription device claim covered by a health benefit plan.

(2) If a pharmacy service entity engages in direct or indirect remuneration with a pharmacy, the pharmacy service entity shall make a reimbursement report available to the

pharmacy upon the pharmacy's request.

(3) For the reimbursement report described in Subsection (2), the pharmacy service entity shall:

(a) include the adjusted compensation amount related to a claim and the reason for the adjusted compensation; and

(b) provide the reimbursement report:

(i) in accordance with the contract between the pharmacy and the pharmacy service entity;

(ii) in an electronic format that is easily accessible; and

(iii) within 120 days after the day on which the pharmacy benefit manager receives a report of a sale of a product or service by the pharmacy.

(4) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy with:

(a) the reasons for any adjustments contained in a reimbursement report; and

(b) an explanation of the reasons provided in Subsection (4)(a).

(5) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by a pharmacist of:

(i) an insured customer's cost share for a covered prescription drug or prescription device;

(ii) the availability of any therapeutically equivalent alternative medications or devices; or

(iii) alternative methods of paying for the prescription medication or prescription device, including paying the cash price, that are less expensive than the cost share of the prescription drug.

(b) Penalties that are prohibited under Subsection (5)(a) include increased utilization review, reduced payments, and other financial disincentives.

(6) A pharmacy benefit manager may not require an insured customer to pay, for a covered prescription drug or prescription device, more than the lesser of:

(a) the applicable cost share of the prescription drug or prescription device being dispensed;

(b) the applicable allowable claim amount of the prescription drug or prescription

device being dispensed;

(c) the applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or

(d) the retail price of the prescription drug or prescription device without prescription drug coverage.

(7) For a contract entered into or renewed on or after May 12, 2020, a pharmacy benefit manager may not engage in direct or indirect remuneration that results in a reduction in total compensation received by a pharmacy from the pharmacy benefit manager for the sale of a drug, device, or other product or service unless the pharmacy benefit manager provides the pharmacy with at least 30 days notice of the direct or indirect remuneration.

Section 5. Section **31A-46-303** is amended to read:

31A-46-303. Insurer and pharmacy benefit management services -- Registration -- Maximum allowable cost -- Audit restrictions.

(1) As used in 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) 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.

Section 6. Section **31A-46-304** is amended to read:

31A-46-304. Claims practices.

(1) A pharmacy benefit manager shall permit a pharmacy to collect the amount of a customer's cost share from any source.

(2) A pharmacy benefit manager may not deny or reduce a reimbursement to a pharmacy or a pharmacist after the adjudication of the claim, unless:

(a) the pharmacy or pharmacist submitted the original claim fraudulently;

(b) the original reimbursement was incorrect because:

(i) the pharmacy or pharmacist had already been paid for the pharmacy service; or

(ii) an unintentional error resulted in an incorrect reimbursement; or

(c) the pharmacy service was not rendered by the pharmacy or pharmacist.

(3) Subsection (2) does not apply if[~~: (a) {~~] ~~an investigative audit~~] any form of an investigation or audit of pharmacy records for fraud, waste, abuse, or other intentional misrepresentation [~~indicates~~] proves that the pharmacy or pharmacist engaged in criminal wrongdoing, fraud, or other intentional misrepresentation[~~; or~~].

[~~(b) the reimbursement is reduced as the result of the reconciliation of a reimbursement amount under a performance contract if:~~]

[~~(i) the performance contract lays out clear performance standards under which the reimbursement for a specific drug may be increased or decreased; and~~]

[~~(ii) the agreement between the pharmacy benefit manager and the pharmacy or pharmacist explicitly states, in a separate document that is signed by the pharmacy benefit manager and the pharmacy or pharmacist, that the provisions of Subsection (2) do not apply.~~]

Section 7. Section **31A-46-305** is enacted to read:

31A-46-305. Applicability -- Pharmacy contracting -- Notification of pharmacies -- Uniform applicability of plan provisions -- Pharmacy benefit manager contracts with provider networks -- Pharmacy promotion prohibited -- Mandatory mail order prohibited -- ~~{Provider directory -- }~~Informing customers -- Cost sharing reductions prohibited~~{ -- Automatic fills and refills}~~.

(1) As used in this section, "provider network" means pharmacies with which an insurer contracts for purposes of a health benefit plan.

(2) This section applies to:

(a) a health benefit plan that:

(i) includes a pharmacy benefit; and

(ii) is entered into or renewed on or after January 1, 2021; and

(b) a health benefit plan that is:

(i) offered to state employees under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act; and

(ii) described in Subsection (2)(a).

~~{ (3) An insurer may not exclude from a health benefit plan provider network a pharmacy willing to abide by the terms and conditions of the health benefit plan.~~

~~}~~ (~~{4}~~3) An insurer that offers a health benefit plan shall provide to each pharmacy within the geographic area covered by the health benefit plan the notice described by Subsection (~~{5}~~4).

(~~{5}~~4) (a) The notice required in Subsection (~~{4}~~3) shall:

(i) be provided no later than 60 days before the day on which coverage for the geographic area takes effect; and

(ii) inform each pharmacy that the pharmacy may be included in the health benefit plan's provider network if, within 60 days, the pharmacy enters into a contract to abide by the terms and conditions of the health benefit plan.

(b) If the geographic area covered by a health benefit plan is expanded, the notice required under Subsection (~~{4}~~3) applies only to pharmacies within the expanded coverage area.

(~~{6}~~5) A health benefit plan's terms and conditions for coverage of pharmacy products and services, including enrollee cost sharing, provider reimbursement, and dispensing quantities:

(a) shall apply:

(i) uniformly across all enrollees within:

(A) a benefit category;

(B) a copayment level; or

(C) any other enrollee classification established by the health benefit plan; and

(ii) uniformly across all pharmacies in the health benefit plan's provider network.

({7}6) A pharmacy benefit manager may not enter into or renew a contract with a pharmacy in the provider network of a health benefit plan unless the terms and conditions for coverage and total compensation for products and services provided by the pharmacy to an enrollee of the health benefit plan, including compensation from the enrollee, the health benefit plan, and the pharmacy benefit manager, are identical to the terms and conditions for coverage and total compensation for products and services provided by each of the other pharmacies in the provider network to an enrollee of the health benefit plan.

({8}7) (a) An insurer may not promote the use of one pharmacy in a health benefit plan's provider network, including an out-of-state mail service pharmacy, over another pharmacy in the health benefit plan's provider network.

(b) Subsection (7)(a) does not apply to the Public Employees' Benefit and Insurance Program for a specialty drug.

({9}8) An insurer that offers a health benefit plan may not require an enrollee to use an out-of-state mail service pharmacy as a condition for coverage of pharmacy products or services by the health benefit plan.

{ ~~(10) An insurer shall provide to a health benefit plan enrollee any change to the pharmacies in a health benefit plan's provider network within 30 days after the day on which the change occurs.~~

} ({11}9) An insurer may not prohibit a pharmacy in a health benefit plan's provider network from informing customers that products and services provided by the pharmacy are covered by the health benefit plan.

({12}10) A pharmacy included in a health benefit plan's provider network may not:

(a) waive, discount, or subsidize the health benefit plan's required deductible, copayment, or coinsurance; or

(b) otherwise provide the pharmacy's products or services to an enrollee of the health benefit plan on terms that differ from those established by the health benefit plan.

{ ~~(13) (a) An out-of-state mail service pharmacy may not automatically fill or refill a prescription without the prior written consent of the patient for whom the prescription is issued.~~

~~(b) Enrollment in a health benefit plan does not constitute consent under Subsection~~

~~(13)(a).~~

~~}~~ Section 8. Section **31A-46-306** is enacted to read:

31A-46-306. Distribution of manufacturer rebates.

(1) As used in this section:

(a) "Enrollee's cost share" means the sum of any copayment, deductible, and coinsurance.

(b) "Pharmacy product" means a prescription drug or prescription device sold by a pharmacy.

(2) This section applies to ~~{rebates}~~a rebate distributed by a pharmacy benefit manager pursuant to a contract:

(a) between the pharmacy benefit manager and an insurer; and

(b) that is entered into or renewed on or after January 1, 2021.

(3) (a) Except as provided in Subsection (~~{5}~~3)(b),~~{ the portion of a rebate not retained by}~~ a pharmacy benefit manager:

(i) shall distribute a rebate between an insurer and an enrollee in accordance with Subsection (4); and

(ii) may not retain any portion of a rebate.

(b) An enrollee's portion of a rebate distributed under Subsection (3)(a) may exceed the proportion of the amount paid by the enrollee if:

(i) the enrollee receives a distribution under Subsection (3)(a) that is higher than the proportion of the amount paid by the enrollee; and

(ii) the contract between the pharmacy benefit manager and the insurer authorizes the higher distribution to the enrollee.

(4) (a) A rebate shall be distributed between an insurer and an enrollee~~{:~~

~~(a) (i) }~~ in proportion to the amount paid~~{ by the insurer and the enrollee}~~, respectively, for a pharmacy product~~{; and~~

~~(ii) in accordance with Subsection (4).~~

~~(b) For purposes of Subsection (3)(a)(i), the amount an enrollee pays for a pharmacy product is}~~ by:

(i) the insurer; and

(ii) the enrollee in the form of the enrollee's cost share.

({~~(4) (a)~~}b) {~~Notwithstanding Subsection 31A-46-305(12), a~~}A pharmacy benefit manager shall distribute the enrollee's portion of a rebate:

(i) at the time the pharmacy product is sold to the enrollee; and

(ii) as a non-cash offset to the enrollee's cost share for purchase of the pharmacy product.

({~~(b)~~}c) If the enrollee's portion of a rebate exceeds the enrollee's cost share for purchase of the pharmacy product, the pharmacy benefit manager shall:

(i) make the non-cash offset required under Subsection (4)({~~(a)~~}b)(ii); and

(ii) pay or credit to the enrollee the difference between the enrollee's portion of the rebate and the non-cash offset required under Subsection (4)({~~(a)~~}b)(ii) in a manner determined by contract between the pharmacy benefit manager and the insurer.

({~~(c)~~}d) The pharmacy benefit manager shall distribute the insurer's portion of the rebate in accordance with the contract between the pharmacy benefit manager and the insurer.

~~{ (5) Notwithstanding Subsection (3), an enrollee's portion of a rebate distributed under Subsection (4) may exceed the proportion of the amount paid by the enrollee if the contract between the pharmacy benefit manager and the insurer authorizes a higher distribution to the enrollee.~~

~~}~~ Section 9. Section **31A-46-307** is enacted to read:

31A-46-307. Pharmacy benefit manager reporting.

A pharmacy benefit manager may not enter into or renew a contract with an insurer on or after January 1, 2021, to administer or manage rebate contracting or rebate administration unless the pharmacy benefit manager agrees to regularly report to the insurer detailed, claim-level information regarding pharmaceutical manufacturer rebates received by the pharmacy benefit manager under the contract.

Section 10. Section ~~**{31A-46-308}**~~**31A-47-101** is enacted to read:

CHAPTER 47. PRESCRIPTION DRUG PRICE TRANSPARENCY ACT

~~**{31A-46-308. Pharmaceutical manufacturer reporting.**~~

~~**A pharmaceutical}**~~**31A-47-101. Title.**

This chapter is known as "Prescription Drug Price Transparency Act."

Section 11. Section **31A-47-102** is enacted to read:

31A-47-102. Definitions.

As used in this chapter:

(1) "Drug" means a prescription drug, as defined in Section 58-17b-102.

(2) "Insurer" means the same as that term is defined in Section 31A-22-634.

(3) "Manufacturer" means a person that is engaged in the manufacturing of a drug that is available for purchase by residents of the state.

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

Section 12. Section **31A-47-103** is enacted to read:

31A-47-103. Manufacturer reports -- Insurer report -- Publication by department.

(1) No later than January 15 of each year, a manufacturer shall report to the ~~{Legislature at least once each calendar quarter}~~department the current wholesale acquisition cost of ~~{each prescription drug}~~drugs that are:

(~~{1}~~a) manufactured by the manufacturer~~{ manufactures}~~; and

(~~{2}~~b) ~~{ is}~~ available for purchase by residents of the state.

(2) (a) A manufacturer of a drug shall report to the department the information described in Subsection (2)(b) no more than 30 days after the day on which an increase to the wholesale acquisition cost of the drug results in an increase to the wholesale acquisition cost of the drug of:

(i) 40 percent or more over the preceding three years; or

(ii) 15 percent or more over the preceding twelve months.

(b) The manufacturer shall report:

(i) (A) the name of the drug;

(B) the dosage form of the drug; and

(C) the strength of the drug;

(ii) whether the drug is a brand name drug or a generic drug;

(iii) the effective date of the increase in the wholesale acquisition cost of the drug;

(iv) the factors that led to the increase in the wholesale acquisition cost of the drug and the significance of each factor;

(v) the manufacturer's company-wide research and development costs for the most recent year for which final audit data is available;

(vi) the name of each of the manufacturer's drugs approved by the United States Food

and Drug Administration during the preceding three calendar years; and

(vii) the names of drugs manufactured by the manufacturer that lost patent exclusivity in the United States during the preceding three calendar years.

(c) Subsection (2)(a) applies only to a drug with a wholesale acquisition cost of at least $100 for a 30-day supply before the effective date of the increase in the wholesale acquisition cost of the drug.

(d) The quality and types of information that a manufacturer submits to the department under Subsection (2)(a) shall be consistent with the quality and types of information the manufacturer includes in:

(i) the manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K; and

(ii) other public disclosures.

(3) No later than February 1 of each year, an insurer shall report to the department in aggregate the following information for the preceding plan year for health benefit plans offered by the insurer:

(a) for the 25 drugs for which the greatest number of claims were made:

(i) the name of the drug;

(ii) the dosage form of the drug; and

(iii) the strength of the drug;

(b) the percentage increase over the previous year in net spending for all drugs;

(c) the percentage of the increase in premiums over the previous year attributable to all drugs;

(d) the percentage of specialty drugs with utilization management requirements; and

(e) the effect of specialty drug utilization management on premiums.

(4) The department shall publish on the department's website:

(a) no later than March 1 of each year, information reported to the department under Subsection (1);

(b) no later than 60 days after receiving the information, information reported to the department under Subsection (2); and

(c) no later than May 1 of each year, information reported to the department under Subsection (3).

HB0272S01 compared with HB0272