

**Senator Evan J. Vickers** proposes the following substitute bill:

**PHARMACY BENEFIT MANAGER REVISIONS**

2020 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Evan J. Vickers**

House Sponsor: Steve Eliason

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**LONG TITLE**

**General Description:**

This bill amends provisions relating to pharmacy benefit managers.

**Highlighted Provisions:**

This bill:

- ▶ creates and amends definitions;
- ▶ requires pharmacy benefit managers and insurers to use unique identifiers for plans managed by a Medicaid managed care organization;
- ▶ prohibits a pharmacy benefit manager from prohibiting certain actions by an in-network pharmacy;
- ▶ prohibits a pharmacy benefit manager from charging an insured customer more for use of a pharmacy that offers delivery or mail-order services;
- ▶ prohibits certain actions by a pharmacy benefit manager or third party with respect to a 340B entity; and
- ▶ makes technical and corresponding changes.

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

None



26 **Utah Code Sections Affected:**

27 AMENDS:

28 **26-18-405**, as last amended by Laws of Utah 2016, Chapters 168, 222, and 394

29 **31A-46-102**, as enacted by Laws of Utah 2019, Chapter 241

30 **31A-46-302**, as renumbered and amended by Laws of Utah 2019, Chapter 241

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

32 ENACTS:

33 **31A-46-305**, Utah Code Annotated 1953



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

36 Section 1. Section **26-18-405** is amended to read:

37 **26-18-405. Waivers to maximize replacement of fee-for-service delivery model --**

38 **Cost of mandated program changes.**

39 (1) The department shall develop a waiver program in the Medicaid program to replace  
40 the fee-for-service delivery model with one or more risk-based delivery models.

41 (2) The waiver program shall:

42 (a) restructure the program's provider payment provisions to reward health care  
43 providers for delivering the most appropriate services at the lowest cost and in ways that,  
44 compared to services delivered before implementation of the waiver program, maintain or  
45 improve recipient health status;

46 (b) restructure the program's cost sharing provisions and other incentives to reward  
47 recipients for personal efforts to:

48 (i) maintain or improve their health status; and

49 (ii) use providers that deliver the most appropriate services at the lowest cost;

50 (c) identify the evidence-based practices and measures, risk adjustment methodologies,  
51 payment systems, funding sources, and other mechanisms necessary to reward providers for  
52 delivering the most appropriate services at the lowest cost, including mechanisms that:

53 (i) pay providers for packages of services delivered over entire episodes of illness  
54 rather than for individual services delivered during each patient encounter; and

55 (ii) reward providers for delivering services that make the most positive contribution to  
56 a recipient's health status;

57 (d) limit total annual per-patient-per-month expenditures for services delivered through  
58 fee-for-service arrangements to total annual per-patient-per-month expenditures for services  
59 delivered through risk-based arrangements covering similar recipient populations and services;  
60 and

61 (e) except as provided in Subsection (4), limit the rate of growth in  
62 per-patient-per-month General Fund expenditures for the program to the rate of growth in  
63 General Fund expenditures for all other programs, when the rate of growth in the General Fund  
64 expenditures for all other programs is greater than zero.

65 (3) To the extent possible, the department shall operate the waiver program with the  
66 input of stakeholder groups representing those who will be affected by the waiver program.

67 (4) (a) For purposes of this Subsection (4), "mandated program change" shall be  
68 determined by the department in consultation with the Medicaid accountable care  
69 organizations, and may include a change to the state Medicaid program that is required by state  
70 or federal law, state or federal guidance, policy, or the state Medicaid plan.

71 (b) A mandated program change shall be included in the base budget for the Medicaid  
72 program for the fiscal year in which the Medicaid program adopted the mandated program  
73 change.

74 (c) The mandated program change is not subject to the limit on the rate of growth in  
75 per-patient-per-month General Fund expenditures for the program established in Subsection  
76 (2)(e), until the fiscal year following the fiscal year in which the Medicaid program adopted the  
77 mandated program change.

78 (5) A managed care organization or a pharmacy benefit manager that provides a  
79 pharmacy benefit to an enrollee shall establish a unique group number, payment classification  
80 number, or bank identification number for each Medicaid managed care organization plan for  
81 which the managed care organization or pharmacy benefit manager provides a pharmacy  
82 benefit.

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

84 **31A-46-102. Definitions.**

85 As used in this chapter:

86 (1) "340B drug discount program" means the 340B drug discount program described in  
87 42 U.S.C. Sec. 256b.

88 (2) "340B entity" means:

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

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

91 (c) a pharmacy contracting with an entity participating in the 340B drug discount

92 program to dispense drugs purchased through the 340B drug discount program.

93 ~~[(1)]~~ (3) "Administrative fee" means any payment, other than a rebate, that a  
94 pharmaceutical manufacturer makes directly or indirectly to a pharmacy benefit manager.

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

97 ~~[(2)]~~ (5) "Contracting insurer" means an insurer ~~[as defined in Section 31A-22-636]~~  
98 with whom a pharmacy benefit manager contracts to provide a pharmacy benefit management  
99 service.

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

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

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

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

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

107 (9) "Maximum allowable cost" means:

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

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

112 (10) "Medicaid program" means the same as that term is defined in Section 26-18-2.

113 (11) "Obsolete" means a product that may be listed in national drug pricing compendia  
114 but is no longer available to be dispensed based on the expiration date of the last lot  
115 manufactured.

116 ~~[(3)]~~ (12) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

117 ~~[(4)]~~ (13) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

118 ~~[(5)]~~ (14) "Pharmacy benefits management service" means any of the following

119 services provided to a health benefit plan, or to a participant of a health benefit plan:

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

121 (b) administering or managing a prescription drug benefit provided by the health

122 benefit plan for the benefit of a participant of the health benefit plan, including administering

123 or managing:

124 (i) a mail service pharmacy;

125 (ii) a specialty pharmacy;

126 (iii) claims processing;

127 (iv) payment of a claim;

128 (v) retail network management;

129 (vi) clinical formulary development;

130 (vii) clinical formulary management services;

131 (viii) rebate contracting;

132 (ix) rebate administration;

133 (x) a participant compliance program;

134 (xi) a therapeutic intervention program;

135 (xii) a disease management program; or

136 (xiii) a service that is similar to, or related to, a service described in Subsection [~~(5)~~]

137 (14)(a) or [~~(5)~~] (14)(b)(i) through (xii).

138 [~~(6)~~] (15) "Pharmacy benefit manager" means a person licensed under this chapter to

139 provide a pharmacy benefits management service.

140 [~~(7)~~] (16) "Pharmacy service" means a product, good, or service provided to an

141 individual by a pharmacy or pharmacist.

142 (17) "Pharmacy services administration organization" means an entity that contracts

143 with a pharmacy to assist with third-party payer interactions and administrative services related

144 to third-party payer interactions, including:

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

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

147 (18) "Pharmacy service entity" means:

148 (a) a pharmacy services administration organization; or

149 (b) a pharmacy benefit manager.

150 (19) "Prescription device" means the same as that term is defined in Section  
151 58-17b-102.

152 ~~[(8)]~~ (20) (a) "Rebate" means a refund, discount, or other price concession that is paid  
153 by a pharmaceutical manufacturer to a pharmacy benefit manager based on a prescription  
154 drug's utilization or effectiveness.

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

156 (21) (a) "Reimbursement report" means a report on the adjustment in total  
157 compensation for a claim.

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

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

162 Section 3. Section **31A-46-302** is amended to read:

163 **31A-46-302. Direct or indirect remuneration by pharmacy benefit managers --**

164 **Disclosure of customer costs -- Limit on customer payment for prescription drugs.**

165 ~~[(1) As used in this section:]~~

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

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

170 ~~[(c) "Direct or indirect remuneration" means any adjustment in the total~~  
171 ~~compensation:]~~

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

174 ~~[(ii) that is determined after the sale of the product or service.]~~

175 ~~[(d) "Health benefit plan" means the same as that term is defined in Section~~  
176 ~~31A-1-301.]~~

177 ~~[(e) "Pharmacy reimbursement" means the amount paid to a pharmacy by a pharmacy~~  
178 ~~benefit manager for a dispensed prescription drug.]~~

179 ~~[(f) "Pharmacy services administration organization" means an entity that contracts~~  
180 ~~with a pharmacy to assist with third-party payer interactions and administrative services related~~

181 to third-party payer interactions, including:]

182 [~~(i) contracting with a pharmacy benefit manager on behalf of the pharmacy; and]~~

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

184 [~~(g) "Pharmacy service entity" means:]~~

185 [~~(i) a pharmacy services administration organization; or]~~

186 [~~(ii) a pharmacy benefit manager.]~~

187 [~~(h) (i) "Reimbursement report" means a report on the adjustment in total~~  
188 ~~compensation for a claim.]~~

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

191 [~~(i) "Sale" means a prescription drug claim covered by a health benefit plan.]~~

192 [~~(2)~~] (1) If a pharmacy service entity engages in direct or indirect remuneration with a  
193 pharmacy, the pharmacy service entity shall make a reimbursement report available to the  
194 pharmacy upon the pharmacy's request.

195 [~~(3)~~] (2) For the reimbursement report described in Subsection [~~(2)~~] (1), the pharmacy  
196 service entity shall:

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

199 (b) provide the reimbursement report:

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

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

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

205 [~~(4)~~] (3) A pharmacy service entity shall, upon a pharmacy's request, provide the  
206 pharmacy with:

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

208 (b) an explanation of the reasons provided in Subsection [~~(4)~~] (3)(a).

209 [~~(5)~~] (4) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by  
210 a pharmacist of:

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

212 (ii) the availability of any therapeutically equivalent alternative medications; or  
213 (iii) alternative methods of paying for the prescription medication, including paying the  
214 cash price, that are less expensive than the cost share of the prescription drug.

215 (b) Penalties that are prohibited under Subsection ~~[(5)]~~ (4)(a) include increased  
216 utilization review, reduced payments, and other financial disincentives.

217 ~~[(6)]~~ (5) A pharmacy benefit manager may not require an insured customer to pay, for a  
218 covered prescription drug, more than the lesser of:

- 219 (a) the applicable cost share of the prescription drug being dispensed;
- 220 (b) the applicable allowable claim amount of the prescription drug being dispensed;
- 221 (c) the applicable pharmacy reimbursement of the prescription drug being dispensed; or
- 222 (d) the retail price of the drug without prescription drug coverage.

223 (6) A pharmacy benefit manager or an insurer may not, directly or indirectly:

224 (a) prohibit an in-network retail pharmacy from:

225 (i) mailing or delivering a prescription drug to an enrollee as a service of the  
226 in-network retail pharmacy;

227 (ii) charging a shipping or handling fee to an enrollee who requests that the in-network  
228 retail pharmacy mail or deliver a prescription drug to the enrollee; or

229 (iii) offering or soliciting the services described in Subsection (6)(a)(i) to an enrollee;

230 or

231 (b) charge an enrollee who uses an in-network retail pharmacy that offers delivery or  
232 mail-order services a fee or copayment that is higher than the fee or copayment the enrollee  
233 would pay if the enrollee used an in-network retail pharmacy that does not offer delivery or  
234 mail-order services.

235 Section 4. Section 31A-46-303 is amended to read:

236 **31A-46-303. Insurer and pharmacy benefit management services -- Registration**  
237 **-- Maximum allowable cost -- Audit restrictions.**

238 ~~[(1) As used in this section:]~~

239 ~~[(a) "Maximum allowable cost" means:]~~

240 ~~[(i) a maximum reimbursement amount for a group of pharmaceutically and~~  
241 ~~therapeutically equivalent drugs; or]~~

242 ~~[(ii) any similar reimbursement amount that is used by a pharmacy benefit manager to~~

243 reimburse pharmacies for multiple source drugs.]

244 [~~(b)~~ "Obsolete" means a product that may be listed in national drug pricing compendia  
245 but is no longer available to be dispensed based on the expiration date of the last lot  
246 manufactured.]

247 [~~(c)~~ "Pharmacy benefit manager" means a person or entity that provides pharmacy  
248 benefit management services as defined in Section ~~49-20-502~~ on behalf of an insurer as defined  
249 in Subsection ~~31A-22-636(1)~~.]

250 [~~(2)~~] (1) An insurer and an insurer's pharmacy benefit manager is subject to the  
251 pharmacy audit provisions of Section ~~58-17b-622~~.

252 [~~(3)~~] (2) A pharmacy benefit manager shall not use maximum allowable cost as a basis  
253 for reimbursement to a pharmacy unless:

254 (a) the drug is listed as "A" or "B" rated in the most recent version of the United States  
255 Food and Drug Administration's approved drug products with therapeutic equivalent  
256 evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating  
257 by a nationally recognized reference; and

258 (b) the drug is:

259 (i) generally available for purchase in this state from a national or regional wholesaler;  
260 and

261 (ii) not obsolete.

262 [~~(4)~~] (3) The maximum allowable cost may be determined using comparable and  
263 current data on drug prices obtained from multiple nationally recognized, comprehensive data  
264 sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs  
265 that are available for purchase by pharmacies in the state.

266 [~~(5)~~] (4) For every drug for which the pharmacy benefit manager uses maximum  
267 allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall:

268 (a) include in the contract with the pharmacy information identifying the national drug  
269 pricing compendia and other data sources used to obtain the drug price data;

270 (b) review and make necessary adjustments to the maximum allowable cost, using the  
271 most recent data sources identified in Subsection [~~(5)~~] (4)(a), at least once per week;

272 (c) provide a process for the contracted pharmacy to appeal the maximum allowable  
273 cost in accordance with Subsection [~~(6)~~] (5); and

274 (d) include in each contract with a contracted pharmacy a process to obtain an update  
275 to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily  
276 available and accessible.

277 ~~[(6)]~~ (5) (a) The right to appeal in Subsection ~~[(5)]~~ (4)(c) shall be:

278 (i) limited to 21 days following the initial claim adjudication; and

279 (ii) investigated and resolved by the pharmacy benefit manager within 14 business  
280 days.

281 (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted  
282 pharmacy with the reason for the denial and the identification of the national drug code of the  
283 drug that may be purchased by the pharmacy at a price at or below the price determined by the  
284 pharmacy benefit manager.

285 ~~[(7)]~~ (6) The contract with each pharmacy shall contain a dispute resolution mechanism  
286 in the event either party breaches the terms or conditions of the contract.

287 ~~[(8)]~~ (7) This section does not apply to a pharmacy benefit manager when the  
288 pharmacy benefit manager is providing pharmacy benefit management services on behalf of the  
289 ~~[state]~~ Medicaid program.

290 Section 5. Section **31A-46-305** is enacted to read:

291 **31A-46-305. Prohibited actions with respect to a 340B entity.**

292 (1) (a) As used in this section, "third party" means:

293 (i) an insurer; or

294 (ii) an organization that provides health coverage, benefits, or coverage of prescription  
295 drugs as part of workers compensation insurance in accordance with state or federal law.

296 (b) "Third party" does not include an insurer that provides coverage under a policy of  
297 casualty or property insurance.

298 (2) This section applies to contracts entered into or renewed on or after January 1,  
299 2021:

300 (a) between a 340B entity and:

301 (i) a pharmacy benefit manager; or

302 (ii) a third party and:

303 (b) between a pharmacy benefit manager and a third party.

304 (3) A pharmacy benefit manager or third party may not:

305 (a) reimburse a 340B entity for a drug dispensed by the 340B entity less than the  
306 amount the pharmacy benefit manager or third party reimburses a non-340B entity for the drug  
307 that is dispensed by the 340B entity, unless the payment is made by the Medicaid program or  
308 through a Medicaid program managed care plan;

309 (b) require a claim for a drug to include a modifier to indicate that the drug was  
310 purchased through the 340B drug discount program unless the claim is for payment by the  
311 Medicaid program for a drug purchased under the 340B drug discount program; or

312 (c) on the basis that the 340B entity directly or indirectly participates in the 340B drug  
313 discount program:

314 (i) assess a fee, charge-back, or other adjustment on the 340B entity;

315 (ii) restrict access to the pharmacy benefit manager's or third party's network;

316 (iii) require a 340B entity to enter into a contract with a specific pharmacy to

317 participate in the pharmacy benefit manager's or third party's network;

318 (iv) create a restriction or an additional charge on a patient who chooses to receive  
319 drugs from a 340B entity; or

320 (v) create any additional requirements or restrictions on the 340B entity.