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S.B. 184
1st Sub. (Green)

Senator Curtis S. Bramble proposes the following substitute bill:

PRESCRIPTION COST AMENDMENTS

2023 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Curtis S. Bramble

House Sponsor: Karianne Lisonbee

LONG TITLE

General Description:

This bill enacts provisions related to health benefit plan cost sharing.

Highlighted Provisions:

This bill:

- defines terms;
- requires an insurer to calculate any amounts paid on behalf of an individual towards the individual's cost sharing requirement;
- requires a pharmacy benefit manager to calculate any amounts paid on behalf of an individual towards the individual's cost sharing requirement; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

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

ENACTS:

31A-46-311, Utah Code Annotated 1953

REPEALS AND REENACTS:

31A-22-657, as enacted by Laws of Utah 2022, Chapter 198

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

Section 1. Section 31A-22-657 is repealed and reenacted to read:

31A-22-657. Cost sharing requirements for health benefit plans.

(1) As used in this section:

(a) (i) "Cost sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing required by a health benefit plan for a specific health care service covered by the health benefit plan.

(ii) "Cost sharing requirement" includes any copayment, coinsurance, deductible, or annual limitation that is subject to 42 U.S.C. Secs. 18022(c) or 300gg-6(b).

(b) (i) "Health care service" means an item or service furnished to an individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(ii) "Health care service" includes a prescription drug.

(c) "High deductible health plan" means the same as that term is defined in 26 U.S.C. Sec. 223(c)(2).

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

(2) When calculating an enrollee's contribution to any applicable cost sharing requirement for a health care service, an insurer shall include any cost sharing amounts paid:

(a) by the enrollee; or

(b) on behalf of the enrollee by another person.

(3) (a) Except as provided in Subsection (3)(b), an insurer shall calculate cost sharing requirements for a health care service in accordance with Subsection (2) even if the enrollee has not met the enrollee's deductible.

(b) An insurer may calculate cost sharing requirements for a health care service in accordance with Subsection (2) after the enrollee has met the enrollee's minimum deductible under 26 U.S.C. Sec. 223 only if:

(i) the enrollee is enrolled in a health benefit plan that is a high deductible health plan;

(ii) calculating the cost sharing requirements in accordance with Subsection (2) before the enrollee has met the high deductible health plan's minimum deductible under 26 U.S.C. Sec. 223 would result in health savings account ineligibility under 26 U.S.C. Sec. 223; and

(iii) the health care service is not preventive care under 26 U.S.C. Sec. 223(c)(2)(C).

(4) This section applies to any health benefit plan entered into, amended, extended, or renewed on or after January 1, 2024.

(5) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

Section 2. 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~~] enrollee'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~~] enrollee under the enrollee's health benefit plan.

(8) "Cost sharing requirement" means the same as that term is defined in Section 31A-22-657.

[~~(8)~~] (9) "Device" means the same as that term is defined in Section 58-17b-102.

[~~(9)~~] (10) "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)~~] (11) "Dispense" means the same as that term is defined in Section 58-17b-102.

[~~(11)~~] (12) "Drug" means the same as that term is defined in Section 58-17b-102.

(13) "Health care service" means the same as that term is defined in Section 31A-22-657.

(14) "High deductible health plan" means the same as that term is defined in 26 U.S.C. Sec. 223(c)(2).

[~~(12)~~] (15) "Insurer" means the same as that term is defined in Section 31A-22-636.

[~~(13)~~] (16) "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)~~] (17) "Medicaid program" means the same as that term is defined in Section 26-18-2.

[~~(15)~~] (18) "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)~~] (19) "Patient counseling" means the same as that term is defined in Section 58-17b-102.

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

[~~(18)~~] (21) "Pharmaceutical manufacturer" means a pharmaceutical facility that manufactures prescription drugs.

[~~(19)~~] (22) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

[~~(20)~~] (23) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(21)~~] (24) "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)~~] (24)(a) or (24)(b)(i) through (xii).

[~~(22)~~] (25) "Pharmacy benefit manager" means a person licensed under this chapter to provide a pharmacy benefits management service.

[~~(23)~~] (26) "Pharmacy service" means a product, good, or service provided to an individual by a pharmacy or pharmacist.

[~~(24)~~] (27) "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)~~] (28) "Pharmacy service entity" means:

(a) a pharmacy services administration organization; or

(b) a pharmacy benefit manager.

[~~(26)~~] (29) "Prescription device" means the same as that term is defined in Section 58-17b-102.

[~~(27)~~] (30) "Prescription drug" means the same as that term is defined in Section 58-17b-102.

[~~(28)~~] (31) (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)~~] (32) (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)~~] (33) "Retail pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(31)~~] (34) "Sale" means a prescription drug or prescription device claim covered by a health benefit plan.

[~~(32)~~] (35) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C. Sec. 1395w-3a.

Section 3. Section **31A-46-311** is enacted to read:

31A-46-311. Cost sharing requirements for pharmacy benefit managers.

(1) When calculating an enrollee's contribution to any applicable cost sharing requirement for a health care service, a pharmacy benefit manager shall include any cost sharing amounts paid:

(a) by the enrollee; or

(b) on behalf of the enrollee by another person.

(2) (a) Except as provided in Subsection (2)(b), a pharmacy benefit manager shall calculate cost sharing requirements for a health care service in accordance with Subsection (1) even if the enrollee has not met the enrollee's minimum deductible.

(b) A pharmacy benefit manger may calculate cost sharing requirements for a health care service in accordance with Subsection (1) after the enrollee has met the minimum deductible under 26 U.S.C. Sec. 223 only if:

(i) the enrollee is enrolled in a health benefit plan that is a high deductible health plan;

(ii) calculating the cost sharing requirements in accordance with Subsection (1) before the enrollee has met the high deductible health plan's minimum deductible would result in health savings account ineligibility under 26 U.S.C. Sec. 223; and

(iii) the health care service is not preventive care under 26 U.S.C. Sec. 223(c)(2)(C).

(3) This section applies to any health benefit plan entered into, amended, extended, or renewed on or after January 1, 2024.

(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.