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₵ 02-13-24 1:05 PM ₵

**H.B. 425**
**1st Sub. (Buff)**

**Representative Norman K Thurston** proposes the following substitute bill:

# HEALTH INSURANCE BENEFIT AMENDMENTS

2024 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Norman K Thurston**

Senate Sponsor: Curtis S. Bramble

**LONG TITLE**

**General Description:**

This bill amends and enacts provisions related to health insurance benefits.

**Highlighted Provisions:**

This bill:

- defines terms;
- requires the commissioner of the Insurance Department to assist in creating a form if requested;
- modifies network requirements for a health maintenance organization;
- requires a health benefit plan to ensure pharmaceutical rebates are used for certain purposes;
- enacts provisions related to pharmacy network requirements for health benefit plans;
- modifies requirements related to pharmacy audits;
- requires pharmacy benefit manager to offer certain options to self-insured benefit plans; and
- makes technical and conforming changes.

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

This bill provides a special effective date.

**Utah Code Sections Affected:**

AMENDS:

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

**31A-22-618.5**, as last amended by Laws of Utah 2017, Chapter 292

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

**31A-45-303**, as last amended by Laws of Utah 2019, Chapter 193

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

**31A-46-304**, as last amended by Laws of Utah 2020, Chapter 198

**58-17b-622**, as last amended by Laws of Utah 2023, Chapter 329

ENACTS:

**31A-46-311**, Utah Code Annotated 1953

REPEALS:

**31A-46-101**, as last amended by Laws of Utah 2020, Chapter 198

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*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-22-618.5** is amended to read:

**31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(C) coverage mandates enacted after January 1, 2009, that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) may offer a health benefit plan that is not subject to Section 31A-22-618 and Subsection [~~31A-45-303(3)(b)(iii)~~] 31A-45-303(3)(b);

(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and

(c) is not subject to coverage mandates enacted after January 1, 2009, that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsection (3)(a) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 3. Section **31A-22-643** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

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

(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 shall ensure that each pharmaceutical manufacturer rebate is:

(i) passed down to the point of sale to offset an enrollee's deductible or coinsurance; or

(ii) if the enrollee does not have any cost sharing described in Subsection (4)(a)(i), used to reduce premiums or enhance health benefits.

(b) When passing down a rebate as described in Subsection (4)(a), a health benefit plan or the health benefit plan's pharmacy benefit manager may:

(i) for a rebate pass down during the coinsurance phase of a contract, divide the rebate between the health benefit plan and the enrollee in a manner that is proportional to the coinsurance responsibility of the health benefit plan;

(ii) limit the amount passed down to the amount of the enrollee's payment responsibility; or

(iii) estimate the amount of a rebate for a given quarter and adjust the amount of a

rebate passed down to account for any overpayment or underpayment in the subsequent quarter for the same product.

(5) Subsection (4) does not apply:

(a) if the health benefit plan and the health benefit plan's pharmacy benefit manager ensure an enrollee only pays an amount equal to the true net price of a drug less any health benefit plan cost sharing requirement at the time of the prescription drug claim;

(b) if the enrollee is using any form of copay assistance, including direct payment to the enrollee or pharmacy from a pharmaceutical manufacturer; or

(c) to a large employer group health benefit plan if the large employer group health benefit plan uses each rebate received to reduce premiums or enhance health benefits.

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

(7) The Public Employees' Benefit and Insurance Program shall alter plan design to ensure cost neutrality to the state and for compliance with Subsections (4), (5), and (6).

(8) Subsections (4), (5), and (6) apply to a health benefit plan renewed or entered into on or after July 1, 2025.

Section 4. Section **31A-45-303** is amended to read:

**31A-45-303. Network provider contract provisions.**

(1) Managed care organizations may provide for enrollees to receive services or reimbursement in accordance with this section.

(2) (a) Subject to restrictions under this section, a managed care organization may enter into contracts with health care providers under which the health care providers agree to be a network provider and supply services, at prices specified in the contracts, to enrollees.

(b) A network provider contract shall require the network provider to accept the specified payment in this Subsection (2) as payment in full, relinquishing the right to collect amounts other than copayments, coinsurance, and deductibles from the enrollee.

(c) The insurance contract may reward the enrollee for selection of network providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

(3) (a) When reimbursing for services of health care providers that are not network providers, the managed care organization may:

(i) make direct payment to the enrollee; and

(ii) impose a deductible on coverage of health care providers not under contract.

(b) [~~(i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed under:~~]

[~~(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;~~]

[~~(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or~~]

[~~(C) Chapter 14, Foreign Insurers; and~~]

[~~(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed care organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans.~~]

[~~(iii)~~] When selecting health care providers with whom to contract under Subsection (2), a managed care organization [~~described in Subsection (3)(b)(i)~~] may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (6).

(c) For purposes of this section, unfair discrimination between classes of health care providers includes:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly used by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the managed care organization; and

(C) within the scope of practice of the class of health care providers.

(4) Before the enrollee consents to the insurance contract, the managed care organization shall fully disclose to the enrollee that the managed care organization has entered into network provider contracts. The managed care organization shall provide sufficient detail on the network provider contracts to permit the enrollee to agree to the terms of the insurance

contract. The managed care organization shall provide at least the following information:

(a) a list of the health care providers under contract, and if requested their business locations and specialties;

(b) a description of the insured benefits, including deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (5); and

(d) a description of the adverse benefit determination procedures required under Section 31A-22-629.

(5) (a) A managed care organization using network provider contracts shall maintain a quality assurance program for assuring that the care provided by the network providers meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health and Human Services may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the managed care organization and the managed care organization's health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(6) (a) A health care provider or managed care organization may not discriminate against a network provider for agreeing to a contract under Subsection (2).

(b) [~~(i) Subsections (6)(b) and (c) apply to a managed care organization that is described in Subsection (3)(b)(i) and do not apply to a managed care organization described in Subsection (3)(b)(ii).~~]

[~~(ii)~~] A health care provider licensed to treat an illness or injury within the scope of the health care provider's practice, that is willing and able to meet the terms and conditions established by the managed care organization for designation as a network provider, shall be able to apply for and receive the designation as a network provider. Contract terms and

conditions may include reasonable limitations on the number of designated network providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(c) Upon the written request of a provider excluded from a network provider contract, the commissioner may hold a hearing to determine if the managed care organization's exclusion of the provider is based on the criteria set forth in Subsection (6)(b).

(7) Nothing in this section is to be construed as to require a managed care organization to offer a certain benefit or service as part of a health benefit plan.

(8) Notwithstanding Subsection (2) or (6)(b), a managed care organization [~~described in Subsection (3)(b)(i)~~] or third party administrator is not required to, but may, enter into a contract with a licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

Section 5. 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~~] that is directly attributable to the pharmacy benefit manager's activities to invoice, collect, audit, and account for funds received from a pharmaceutical manufacturer.

(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)~~] (20)(a) or [~~(21)(b)(i) through (xii).~~] 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.~~] means all payments that accrue directly or indirectly to a pharmacy benefit manager or a health benefit plan from a pharmaceutical manufacturer.

(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 the pharmacist's services.

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

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) (a) A finding of overpayment or underpayment shall be based on the actual overpayment or underpayment of a specific individual claim.

(b) Any amount to be charged back or recouped due to overpayment may not exceed the amount the pharmacy was overpaid.

[~~(3)~~] (4) Subsection (2) does not apply if:

(a) any form of an investigation or audit of pharmacy records for fraud, waste, abuse, or other intentional misrepresentation indicates 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-46-311** is enacted to read:

**31A-46-311. Options for self-insured benefit plans.**

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

(1) comply with the provisions of Subsections 31A-22-643(4), (5), and (6), collectively and individually; and

(2) do not include spread pricing.

Section 8. Section **58-17b-622** is amended to read:

**58-17b-622. Pharmacy benefit management services -- Auditing of pharmacy records -- Appeals.**

(1) For purposes of this section:

(a) "Audit" means a review of the records of a pharmacy by or on behalf of an entity that finances or reimburses the cost of health care services or pharmaceutical products.

(b) "Audit completion date" means:

(i) for an audit that does not require an on-site visit at the pharmacy, the date on which the pharmacy, in response to the initial audit request, submits records or other documents to the entity conducting the audit, as determined by:

(A) postmark or other evidence of the date of mailing; or

(B) the date of transmission if the records or other documents are transmitted electronically; and

(ii) for an audit that requires an on-site visit at a pharmacy, the date on which the auditing entity completes the on-site visit, including any follow-up visits or analysis which shall be completed within 60 days after the day on which the on-site visit begins.

(c) "Entity" includes:

(i) a pharmacy benefits manager or coordinator;

(ii) a health benefit plan;

(iii) a third party administrator as defined in Section 31A-1-301;

(iv) a state agency; or

(v) a company, group, or agent that represents, or is engaged by, one of the entities described in Subsections (1)(c)(i) through (iv).

(d) "Extrapolation" means a method of using a mathematical formula that uses the audit results from a small sample of insurance claims and projects the results over a larger group of insurance claims.

[~~(d)~~] (e) "Fraud" means an intentional act of deception, misrepresentation, or concealment in order to gain something of value.

[~~(e)~~] (f) "Health benefit plan" means:

(i) a health benefit plan as defined in Section 31A-1-301; or

(ii) a health, dental, medical, Medicare supplement, or conversion program offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(2) (a) Except as provided in Subsection (2)(b), this section applies to:

(i) a contract for the audit of a pharmacy entered into, amended, or renewed on or after July 1, 2012; and

(ii) an entity that conducts an audit of the pharmacy records of a pharmacy licensed under this chapter.

(b) This section does not apply to an audit of pharmacy records:

(i) for a federally funded prescription drug program, including:

(A) the state Medicaid program;

(B) the Medicare Part D program;

(C) a Department of Defense prescription drug program; and

(D) a Veterans Affairs prescription drug program; or

(ii) when fraud or other intentional and willful misrepresentation is alleged and the pharmacy audit entity has evidence that the pharmacy's actions reasonably indicate fraud or intentional and willful misrepresentation.

(3) (a) An audit that involves clinical or professional judgment shall be conducted by or in consultation with a pharmacist who is employed by or working with the auditing entity and who is licensed in the state or another state.

(b) If an audit is conducted on site at a pharmacy, the entity conducting the audit:

(i) shall give the pharmacy 10 days advanced written notice of:

(A) the audit; and

(B) the range of prescription numbers or a date range included in the audit; and

(ii) may not audit a pharmacy during the first five business days of the month, unless the pharmacy agrees to the timing of the audit.

(c) An entity may not audit claims:

(i) submitted more than 18 months prior to the audit, unless:

(A) required by federal law; or

(B) the originating prescription is dated in the preceding six months; or

(ii) that exceed 200 selected prescription claims annually.

(d) Subsection (3)(c)(ii) does not apply to any investigative audit that involves fraud, waste, abuse, or willful misrepresentation.

(4) (a) An entity may not:

(i) include dispensing fees in the calculations of overpayments unless the prescription is considered a misfill;

(ii) recoup funds for prescription clerical or recordkeeping errors, including typographical errors, scrivener's errors, and computer errors on a required document or record unless the audit entity is alleging fraud or other intentional or willful misrepresentation and the audit entity has evidence that the pharmacy's actions reasonably indicate fraud or intentional

and willful misrepresentation;

(iii) recoup funds for refills dispensed in accordance with Section 58-17b-608.1, unless the health benefit plan does not cover the prescription drug dispensed by the pharmacy;

(iv) collect any funds, charge-backs, or penalties until the audit and all appeals are final, unless the audit entity is alleging fraud or other intentional or willful misrepresentation and the audit entity has evidence that the pharmacy's actions reasonably indicate fraud or intentional and willful misrepresentation; or

(v) recoup funds or collect any funds, charge-backs, or penalties from a pharmacy in response to a request for audit unless the pharmacy confirms to the entity the date on which the pharmacy received the request for audit.

(b) Auditors shall only have access to previous audit reports on a particular pharmacy if the previous audit was conducted by the same entity except as required for compliance with state or federal law.

(5) A pharmacy subject to an audit:

(a) may use one or more of the following to validate a claim for a prescription, refill, or change in a prescription:

(i) electronic or physical copies of records of a health care facility, or a health care provider with prescribing authority;

(ii) any prescription that complies with state law;

(iii) the pharmacy's own physical or electronic records; or

(iv) the physical or electronic records, or valid copies of the physical or electronic records, of a practitioner or health care facility as defined in Section 26B-2-201; and

(b) may not be required to provide the following records to validate a claim for a prescription, refill, or change in a prescription:

(i) if the prescription was handwritten, the physical handwritten version of the prescription; or

(ii) a note from the practitioner regarding the patient or the prescription that is not otherwise required for a prescription under state or federal law.

(6) (a) (i) An entity that audits a pharmacy shall establish:

(A) a maximum time for the pharmacy to submit records or other documents to the entity following receipt of an audit request for records or documents; and

(B) a maximum time for the entity to provide the pharmacy with a preliminary audit report following submission of records under Subsection (6)(a)(i)(A).

(ii) The time limits established under Subsections (6)(a)(i)(A) and (B):

(A) shall be identical; and

(B) may not be less than seven days or more than 60 days.

(iii) An entity that audits a pharmacy may not, after the audit completion date, request additional records or other documents from the pharmacy to complete the preliminary audit report described in Subsection (6)(b).

(b) An entity that audits a pharmacy shall provide the pharmacy with a preliminary audit report[~~,~~]:

(i) delivered to the pharmacy or its corporate office of record, within the time limit established under Subsection (6)(a)(i)(B)[~~.~~]; and

(ii) that includes a notation for each suspected error.

(c) (i) Except as provided in Subsection (6)(c)(ii), a pharmacy has 30 days following receipt of the preliminary audit report to respond to questions, provide additional documentation, and comment on and clarify findings of the audit.

(ii) An entity may grant a reasonable extension under Subsection (6)(c)(i) upon request by the pharmacy.

(iii) Receipt of the report under Subsection (6)(c)(i) shall be determined by:

(A) postmark or other evidence of the date of mailing; or

(B) the date of transmission if the report is transmitted electronically.

(iv) If a dispute exists between the records of the auditing entity and the pharmacy, the records maintained by the pharmacy shall be presumed valid for the purpose of the audit.

(7) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow any of the following:

(a) the pharmacy to resubmit a claim using any commercially reasonable method, including fax, mail, or electronic claims submission provided that the period of time when a claim may be resubmitted has not expired under the rules of the plan sponsor[~~,~~] and within 30 days from the day on which the audit report is received by the pharmacy; or

(b) the health benefit plan or other entity that finances or reimburses the cost of health care services or pharmaceutical products to rerun the claim if the health benefit plan or other

entity chooses to rerun the claim at no cost to the pharmacy.

(8) (a) Within 60 days after the completion of the appeals process under Subsection (9), a final audit report shall be delivered to the pharmacy or its corporate office of record.

(b) The final audit report shall include:

(i) a disclosure of any money recovered by the entity that conducted the audit[.]; and

(ii) legal or contractual information supporting any money recovered, recoupments, or penalties included in the report.

(9) (a) An entity that audits a pharmacy shall establish a written appeals process for appealing a preliminary audit report and a final audit report, and shall provide the pharmacy with notice of the written appeals process.

(b) If the pharmacy benefit manager's contract or provider manual contains the information required by this Subsection (9), the requirement for notice is met.

(10) An auditing entity conducting a pharmacy audit may not:

(a) use extrapolation when conducting an audit, including calculating recoupments or penalties for audits, unless otherwise required by federal law or a self-funded insurance plan; or

(b) compensate an employee or contractor participating in the audit in a manner that is based on the amount claimed or the actual amount recouped from the pharmacy being audited.

Section 9. **Repealer.**

This bill repeals:

Section **31A-46-101**, **Title.**

Section 10. **Effective date.**

This bill takes effect on January 1, 2025.