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₵ 02-21-20 3:11 PM ₵

Representative Paul Ray proposes the following substitute bill:

1 # PHARMACY BENEFIT AMENDMENTS

2 2020 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Paul Ray**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

9 This bill amends the Insurance Code.

10 **Highlighted Provisions:**

11 This bill:

12 ▸ renames the Pharmacy Benefit Manager Licensing Act as Pharmacy Benefits;

13 ▸ requires the Insurance Department to annually publish the total value of rebates and
14 administrative fees received by a pharmacy benefit manager from a pharmaceutical
15 manufacturer;

16 ▸ creates and amends definitions;

17 ▸ prohibits a pharmacy benefit manager from prohibiting or penalizing a pharmacist's
18 disclosure of certain information regarding a prescription device;

19 ▸ prohibits a pharmacy benefit manager from requiring an insured customer from
20 paying more than a specified amount for a prescription device;

21 ▸ prohibits a pharmacy benefit manager from reducing a pharmacy's total
22 compensation for the sale of a drug, device, or other product or service unless the
23 pharmacy benefit manager provides the pharmacy with at least 30 days notice;

24 ▸ prohibits a pharmacy benefit manager from denying or reducing a reimbursement to
25 a pharmacy or a pharmacist after the adjudication of a claim unless an investigation

26 or audit proves certain behavior;
27 ▸ prohibits a pharmacy benefit manager from denying or reducing a reimbursement to
28 a pharmacy or pharmacist, after adjudication of a claim, pursuant to a performance
29 contract;
30 ▸ requires an insurer to notify pharmacies that they are eligible to participate in the
31 insurer's health benefit plan on certain conditions;
32 ▸ requires a health benefit plan's terms and conditions for pharmacy coverage to be
33 applied uniformly across enrollees and pharmacies;
34 ▸ prohibits a pharmacy benefit manager from entering into contracts with pharmacies
35 in a health benefit plan's provider network unless the terms and conditions of the
36 contracts for coverage and total compensation are identical;
37 ▸ prohibits an insurer from promoting the use of one pharmacy in a provider network
38 over another, except for the Public Employees' Benefit and Insurance Program with
39 respect to a specialty drug;
40 ▸ prohibits an insurer from requiring the use of an out-of-state mail service pharmacy
41 as a condition for pharmacy coverage;
42 ▸ prohibits an insurer from prohibiting a pharmacy from informing a customer that the
43 pharmacy is covered by a specific health benefit plan;
44 ▸ prohibits a pharmacy from waiving, discounting, or subsidizing a health benefit
45 plan's cost sharing requirements or otherwise providing services on terms that differ
46 from those established by the plan;
47 ▸ requires a pharmacy benefit manager to distribute manufacturer rebates to insurers
48 and enrollees;
49 ▸ prohibits a pharmacy benefit manager from contracting with a health insurer in
50 certain instances unless the pharmacy benefit manager agrees to regularly report to
51 the insurer detailed, claim-level information regarding pharmaceutical manufacturer
52 rebates received by the pharmacy benefit manager in connection with the contract;
53 ▸ requires manufacturers and insurers to report certain information on the cost of
54 prescription drugs to the Insurance Department; and
55 ▸ requires the Insurance Department to publish prescription drug information reported
56 to the department.

57 **Money Appropriated in this Bill:**
58 None
59 **Other Special Clauses:**
60 None
61 **Utah Code Sections Affected:**
62 AMENDS:
63 **31A-46-101**, as enacted by Laws of Utah 2019, Chapter 241
64 **31A-46-102**, as enacted by Laws of Utah 2019, Chapter 241
65 **31A-46-301**, as enacted by Laws of Utah 2019, Chapter 241
66 **31A-46-302**, as renumbered and amended by Laws of Utah 2019, Chapter 241
67 **31A-46-303**, as renumbered and amended by Laws of Utah 2019, Chapter 241
68 **31A-46-304**, as enacted by Laws of Utah 2019, Chapter 241
69 ENACTS:
70 **31A-46-305**, Utah Code Annotated 1953
71 **31A-46-306**, Utah Code Annotated 1953
72 **31A-46-307**, Utah Code Annotated 1953
73 **31A-47-101**, Utah Code Annotated 1953
74 **31A-47-102**, Utah Code Annotated 1953
75 **31A-47-103**, Utah Code Annotated 1953
76

77 *Be it enacted by the Legislature of the state of Utah:*
78 Section 1. Section **31A-46-101** is amended to read:
79 **CHAPTER 46. PHARMACY BENEFITS ACT**
80 **31A-46-101. Title.**
81 This chapter is known as [~~the~~] "Pharmacy [~~Benefit Manager Licensing Act~~] Benefits
82 Act."
83 Section 2. Section **31A-46-102** is amended to read:
84 **31A-46-102. Definitions.**
85 As used in this chapter:
86 (1) "Administrative fee" means any payment, other than a rebate, that a pharmaceutical
87 manufacturer makes directly or indirectly to a pharmacy benefit manager.

88 (2) "Contracting insurer" means an insurer [as defined in Section 31A-22-636] with
89 whom a pharmacy benefit manager contracts to provide a pharmacy benefit management
90 service.
91 (3) "Drug" means the same as that term is defined in Section 58-17b-102.
92 (4) "Insurer" means the same as that term is defined in Section 31A-22-636.
93 (5) "Pharmaceutical facility" means the same as that term is defined in Section
94 58-17b-102.
95 (6) "Pharmaceutical manufacturer" means a pharmaceutical facility that manufactures
96 prescription drugs.
97 [(3)] (7) "Pharmacist" means the same as that term is defined in Section 58-17b-102.
98 [(4)] (8) "Pharmacy" means the same as that term is defined in Section 58-17b-102.
99 [(5)] (9) "Pharmacy benefits management service" means any of the following services
100 provided to a health benefit plan, or to a participant of a health benefit plan:
101 (a) negotiating the amount to be paid by a health benefit plan for a prescription drug; or
102 (b) administering or managing a prescription drug benefit provided by the health
103 benefit plan for the benefit of a participant of the health benefit plan, including administering
104 or managing:
105 (i) a mail service pharmacy;
106 (ii) a specialty pharmacy;
107 (iii) claims processing;
108 (iv) payment of a claim;
109 (v) retail network management;
110 (vi) clinical formulary development;
111 (vii) clinical formulary management services;
112 (viii) rebate contracting;
113 (ix) rebate administration;
114 (x) a participant compliance program;
115 (xi) a therapeutic intervention program;
116 (xii) a disease management program; or
117 (xiii) a service that is similar to, or related to, a service described in Subsection [(5)]
118 (9)(a) or [(5)] (9)(b)(i) through (xii).

119 [(6)] (10) "Pharmacy benefit manager" means a person licensed under this chapter to
120 provide a pharmacy benefits management service.
121 [(7)] (11) "Pharmacy service" means a product, good, or service provided to an
122 individual by a pharmacy or pharmacist.
123 (12) "Prescription device" means the same as that term is defined in Section
124 58-17b-102.
125 (13) "Prescription drug" means the same as that term is defined in Section 58-17b-102.
126 [(8)] (14) (a) "Rebate" means a refund, discount, or other price concession that is paid
127 by a pharmaceutical manufacturer to a pharmacy benefit manager based on a prescription
128 drug's utilization or effectiveness.
129 (b) "Rebate" does not include an administrative fee.
130 (15) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C.
131 Sec. 1395w-3a.
132 Section 3. Section **31A-46-301** is amended to read:
133 **31A-46-301. Reporting requirements.**
134 (1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall
135 report to the department, for the previous calendar year:
136 (a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit
137 manager had a contract;
138 (b) the total value, in the aggregate, of all rebates and administrative fees that are
139 attributable to enrollees of a contracting insurer; and
140 (c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager
141 retained under the pharmacy benefit manager's agreement to provide pharmacy benefits
142 management services to a contracting insurer.
143 (2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a
144 protected record under Title 63G, Chapter 2, Government Records Access and Management
145 Act.
146 (3) (a) The department shall publish the information provided by a pharmacy benefit
147 manager under [Subsection] Subsections (1)(b) and (1)(c) in the annual report described in
148 Section 31A-2-201.2.
149 (b) The department may not publish information submitted under Subsection (1)(b) or

150 (c) in a manner that:
151 (i) makes a [~~specific submission from a contracting insurer or~~] pharmacy benefit
152 manager or contracting insurer identifiable; or
153 (ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2.
154 (c) At least 30 days before the day on which the department publishes the data, the
155 department shall provide a pharmacy benefit manager that submitted data under Subsection
156 (1)(b) or (c) with:
157 (i) a general description of the data that will be published by the department;
158 (ii) an opportunity to submit to the department, within a reasonable period of time and
159 in a manner established by the department by rule made in accordance with Title 63G, Chapter
160 3, Utah Administrative Rulemaking Act:
161 (A) any correction of errors, with supporting evidence and comments; and
162 (B) information that demonstrates that the publication of the data will violate
163 Subsection (3)(b), with supporting evidence and comments.
164 Section 4. Section **31A-46-302** is amended to read:
165 **31A-46-302. Direct or indirect remuneration by pharmacy benefit managers --**
166 **Pharmacist disclosures -- Limit on customer payment for prescription drugs and**
167 **prescription devices -- 30-day notice required to reduce total compensation.**
168 (1) As used in this section:
169 (a) "Allowable claim amount" means the amount paid by an insurer under the
170 customer's health benefit plan.
171 (b) "Cost share" means the amount paid by an insured customer under the customer's
172 health benefit plan.
173 (c) "Direct or indirect remuneration" means any adjustment in the total compensation:
174 (i) received by a pharmacy from a pharmacy benefit manager for the sale of a drug,
175 device, or other product or service; and
176 (ii) that is determined after the sale of the product or service.
177 (d) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.
178 (e) "Pharmacy reimbursement" means the amount paid to a pharmacy by a pharmacy
179 benefit manager for a dispensed prescription drug or prescription device.
180 (f) "Pharmacy services administration organization" means an entity that contracts with

181 a pharmacy to assist with third-party payer interactions and administrative services related to
182 third-party payer interactions, including:
183 (i) contracting with a pharmacy benefit manager on behalf of the pharmacy; and
184 (ii) managing a pharmacy's claims payments from third-party payers.
185 (g) "Pharmacy service entity" means:
186 (i) a pharmacy services administration organization; or
187 (ii) a pharmacy benefit manager.
188 (h) (i) "Reimbursement report" means a report on the adjustment in total compensation
189 for a claim.
190 (ii) "Reimbursement report" does not include a report on adjustments made pursuant to
191 a pharmacy audit or reprocessing.
192 (i) "Sale" means a prescription drug <u>or prescription device</u> claim covered by a health
193 benefit plan.
194 (2) If a pharmacy service entity engages in direct or indirect remuneration with a
195 pharmacy, the pharmacy service entity shall make a reimbursement report available to the
196 pharmacy upon the pharmacy's request.
197 (3) For the reimbursement report described in Subsection (2), the pharmacy service
198 entity shall:
199 (a) include the adjusted compensation amount related to a claim and the reason for the
200 adjusted compensation; and
201 (b) provide the reimbursement report:
202 (i) in accordance with the contract between the pharmacy and the pharmacy service
203 entity;
204 (ii) in an electronic format that is easily accessible; and
205 (iii) within 120 days after the day on which the pharmacy benefit manager receives a
206 report of a sale of a product or service by the pharmacy.
207 (4) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy
208 with:
209 (a) the reasons for any adjustments contained in a reimbursement report; and
210 (b) an explanation of the reasons provided in Subsection (4)(a).
211 (5) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by a

212 pharmacist of:
213 (i) an insured customer's cost share for a covered prescription drug or prescription
214 device;
215 (ii) the availability of any therapeutically equivalent alternative medications or devices;
216 or
217 (iii) alternative methods of paying for the prescription medication or prescription
218 device, including paying the cash price, that are less expensive than the cost share of the
219 prescription drug.
220 (b) Penalties that are prohibited under Subsection (5)(a) include increased utilization
221 review, reduced payments, and other financial disincentives.
222 (6) A pharmacy benefit manager may not require an insured customer to pay, for a
223 covered prescription drug or prescription device, more than the lesser of:
224 (a) the applicable cost share of the prescription drug or prescription device being
225 dispensed;
226 (b) the applicable allowable claim amount of the prescription drug or prescription
227 device being dispensed;
228 (c) the applicable pharmacy reimbursement of the prescription drug or prescription
229 device being dispensed; or
230 (d) the retail price of the prescription drug or prescription device without prescription
231 drug coverage.
232 (7) For a contract entered into or renewed on or after May 12, 2020, a pharmacy benefit
233 manager may not engage in direct or indirect remuneration that results in a reduction in total
234 compensation received by a pharmacy from the pharmacy benefit manager for the sale of a
235 drug, device, or other product or service unless the pharmacy benefit manager provides the
236 pharmacy with at least 30 days notice of the direct or indirect remuneration.
237 Section 5. Section **31A-46-303** is amended to read:
238 **31A-46-303. Insurer and pharmacy benefit management services -- Registration**
239 **-- Maximum allowable cost -- Audit restrictions.**
240 (1) As used in this section:
241 (a) "Maximum allowable cost" means:
242 (i) a maximum reimbursement amount for a group of pharmaceutically and

243 therapeutically equivalent drugs; or
244 (ii) any similar reimbursement amount that is used by a pharmacy benefit manager to
245 reimburse pharmacies for multiple source drugs.
246 (b) "Obsolete" means a product that may be listed in national drug pricing compendia
247 but is no longer available to be dispensed based on the expiration date of the last lot
248 manufactured.
249 (c) " Pharmacy benefit manager" means a person or entity that provides pharmacy
250 benefit management services as defined in Section 49-20-502 on behalf of an insurer [~~as~~
251 ~~defined in Subsection 31A-22-636(1)~~].
252 (2) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy
253 audit provisions of Section 58-17b-622.
254 (3) A pharmacy benefit manager shall not use maximum allowable cost as a basis for
255 reimbursement to a pharmacy unless:
256 (a) the drug is listed as "A" or "B" rated in the most recent version of the United States
257 Food and Drug Administration's approved drug products with therapeutic equivalent
258 evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating
259 by a nationally recognized reference; and
260 (b) the drug is:
261 (i) generally available for purchase in this state from a national or regional wholesaler;
262 and
263 (ii) not obsolete.
264 (4) The maximum allowable cost may be determined using comparable and current
265 data on drug prices obtained from multiple nationally recognized, comprehensive data sources,
266 including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are
267 available for purchase by pharmacies in the state.
268 (5) For every drug for which the pharmacy benefit manager uses maximum allowable
269 cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall:
270 (a) include in the contract with the pharmacy information identifying the national drug
271 pricing compendia and other data sources used to obtain the drug price data;
272 (b) review and make necessary adjustments to the maximum allowable cost, using the
273 most recent data sources identified in Subsection (5)(a), at least once per week;

274 (c) provide a process for the contracted pharmacy to appeal the maximum allowable
275 cost in accordance with Subsection (6); and
276 (d) include in each contract with a contracted pharmacy a process to obtain an update
277 to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily
278 available and accessible.
279 (6) (a) The right to appeal in Subsection (5)(c) shall be:
280 (i) limited to 21 days following the initial claim adjudication; and
281 (ii) investigated and resolved by the pharmacy benefit manager within 14 business
282 days.
283 (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted
284 pharmacy with the reason for the denial and the identification of the national drug code of the
285 drug that may be purchased by the pharmacy at a price at or below the price determined by the
286 pharmacy benefit manager.
287 (7) The contract with each pharmacy shall contain a dispute resolution mechanism in
288 the event either party breaches the terms or conditions of the contract.
289 (8) This section does not apply to a pharmacy benefit manager when the pharmacy
290 benefit manager is providing pharmacy benefit management services on behalf of the state
291 Medicaid program.
292 Section 6. Section **31A-46-304** is amended to read:
293 **31A-46-304. Claims practices.**
294 (1) A pharmacy benefit manager shall permit a pharmacy to collect the amount of a
295 customer's cost share from any source.
296 (2) A pharmacy benefit manager may not deny or reduce a reimbursement to a
297 pharmacy or a pharmacist after the adjudication of the claim, unless:
298 (a) the pharmacy or pharmacist submitted the original claim fraudulently;
299 (b) the original reimbursement was incorrect because:
300 (i) the pharmacy or pharmacist had already been paid for the pharmacy service; or
301 (ii) an unintentional error resulted in an incorrect reimbursement; or
302 (c) the pharmacy service was not rendered by the pharmacy or pharmacist.
303 (3) Subsection (2) does not apply if[~~: (a) an investigative audit~~] any form of an
304 investigation or audit of pharmacy records for fraud, waste, abuse, or other intentional

305 misrepresentation [~~indicates~~] proves that the pharmacy or pharmacist engaged in criminal
306 wrongdoing, fraud, or other intentional misrepresentation[~~; or~~].
307 [~~(b) the reimbursement is reduced as the result of the reconciliation of a reimbursement~~
308 ~~amount under a performance contract if:~~]
309 [~~(i) the performance contract lays out clear performance standards under which the~~
310 ~~reimbursement for a specific drug may be increased or decreased; and~~]
311 [~~(ii) the agreement between the pharmacy benefit manager and the pharmacy or~~
312 ~~pharmacist explicitly states, in a separate document that is signed by the pharmacy benefit~~
313 ~~manager and the pharmacy or pharmacist, that the provisions of Subsection (2) do not apply.~~]
314 Section 7. Section **31A-46-305** is enacted to read:
315 **31A-46-305. Applicability -- Pharmacy contracting -- Notification of pharmacies**
316 **-- Uniform applicability of plan provisions -- Pharmacy benefit manager contracts with**
317 **provider networks -- Pharmacy promotion prohibited -- Mandatory mail order**
318 **prohibited -- Informing customers -- Cost sharing reductions prohibited.**
319 (1) As used in this section, "provider network" means pharmacies with which an
320 insurer contracts for purposes of a health benefit plan.
321 (2) This section applies to:
322 (a) a health benefit plan that:
323 (i) includes a pharmacy benefit; and
324 (ii) is entered into or renewed on or after January 1, 2021; and
325 (b) a health benefit plan that is:
326 (i) offered to state employees under Title 49, Chapter 20, Public Employees' Benefit
327 and Insurance Program Act; and
328 (ii) described in Subsection (2)(a).
329 (3) An insurer that offers a health benefit plan shall provide to each pharmacy within
330 the geographic area covered by the health benefit plan the notice described by Subsection (4).
331 (4) (a) The notice required in Subsection (3) shall:
332 (i) be provided no later than 60 days before the day on which coverage for the
333 geographic area takes effect; and
334 (ii) inform each pharmacy that the pharmacy may be included in the health benefit
335 plan's provider network if, within 60 days, the pharmacy enters into a contract to abide by the

336 terms and conditions of the health benefit plan.
337 (b) If the geographic area covered by a health benefit plan is expanded, the notice
338 required under Subsection (3) applies only to pharmacies within the expanded coverage area.
339 (5) A health benefit plan's terms and conditions for coverage of pharmacy products and
340 services, including enrollee cost sharing, provider reimbursement, and dispensing quantities:
341 (a) shall apply:
342 (i) uniformly across all enrollees within:
343 (A) a benefit category;
344 (B) a copayment level; or
345 (C) any other enrollee classification established by the health benefit plan; and
346 (ii) uniformly across all pharmacies in the health benefit plan's provider network.
347 (6) A pharmacy benefit manager may not enter into or renew a contract with a
348 pharmacy in the provider network of a health benefit plan unless the terms and conditions for
349 coverage and total compensation for products and services provided by the pharmacy to an
350 enrollee of the health benefit plan, including compensation from the enrollee, the health benefit
351 plan, and the pharmacy benefit manager, are identical to the terms and conditions for coverage
352 and total compensation for products and services provided by each of the other pharmacies in
353 the provider network to an enrollee of the health benefit plan.
354 (7) (a) An insurer may not promote the use of one pharmacy in a health benefit plan's
355 provider network, including an out-of-state mail service pharmacy, over another pharmacy in
356 the health benefit plan's provider network.
357 (b) Subsection (7)(a) does not apply to the Public Employees' Benefit and Insurance
358 Program for a specialty drug.
359 (8) An insurer that offers a health benefit plan may not require an enrollee to use an
360 out-of-state mail service pharmacy as a condition for coverage of pharmacy products or
361 services by the health benefit plan.
362 (9) An insurer may not prohibit a pharmacy in a health benefit plan's provider network
363 from informing customers that products and services provided by the pharmacy are covered by
364 the health benefit plan.
365 (10) A pharmacy included in a health benefit plan's provider network may not:
366 (a) waive, discount, or subsidize the health benefit plan's required deductible,

367 copayment, or coinsurance; or
368 (b) otherwise provide the pharmacy's products or services to an enrollee of the health
369 benefit plan on terms that differ from those established by the health benefit plan.
370 Section 8. Section **31A-46-306** is enacted to read:
371 **31A-46-306. Distribution of manufacturer rebates.**
372 (1) As used in this section:
373 (a) "Enrollee's cost share" means the sum of any copayment, deductible, and
374 coinsurance.
375 (b) "Pharmacy product" means a prescription drug or prescription device sold by a
376 pharmacy.
377 (2) This section applies to a rebate distributed by a pharmacy benefit manager pursuant
378 to a contract:
379 (a) between the pharmacy benefit manager and an insurer; and
380 (b) that is entered into or renewed on or after January 1, 2021.
381 (3) (a) Except as provided in Subsection (3)(b), a pharmacy benefit manager:
382 (i) shall distribute a rebate between an insurer and an enrollee in accordance with
383 Subsection (4); and
384 (ii) may not retain any portion of a rebate.
385 (b) An enrollee's portion of a rebate distributed under Subsection (3)(a) may exceed the
386 proportion of the amount paid by the enrollee if:
387 (i) the enrollee receives a distribution under Subsection (3)(a) that is higher than the
388 proportion of the amount paid by the enrollee; and
389 (ii) the contract between the pharmacy benefit manager and the insurer authorizes the
390 higher distribution to the enrollee.
391 (4) (a) A rebate shall be distributed between an insurer and an enrollee in proportion to
392 the amount paid, respectively, for a pharmacy product by:
393 (i) the insurer; and
394 (ii) the enrollee in the form of the enrollee's cost share.
395 (b) A pharmacy benefit manager shall distribute the enrollee's portion of a rebate:
396 (i) at the time the pharmacy product is sold to the enrollee; and
397 (ii) as a non-cash offset to the enrollee's cost share for purchase of the pharmacy

398 product.
399 (c) If the enrollee's portion of a rebate exceeds the enrollee's cost share for purchase of
400 the pharmacy product, the pharmacy benefit manager shall:
401 (i) make the non-cash offset required under Subsection (4)(b)(ii); and
402 (ii) pay or credit to the enrollee the difference between the enrollee's portion of the
403 rebate and the non-cash offset required under Subsection (4)(b)(ii) in a manner determined by
404 contract between the pharmacy benefit manager and the insurer.
405 (d) The pharmacy benefit manager shall distribute the insurer's portion of the rebate in
406 accordance with the contract between the pharmacy benefit manager and the insurer.
407 Section 9. Section **31A-46-307** is enacted to read:
408 **31A-46-307. Pharmacy benefit manager reporting.**
409 A pharmacy benefit manager may not enter into or renew a contract with an insurer on
410 or after January 1, 2021, to administer or manage rebate contracting or rebate administration
411 unless the pharmacy benefit manager agrees to regularly report to the insurer detailed,
412 claim-level information regarding pharmaceutical manufacturer rebates received by the
413 pharmacy benefit manager under the contract.
414 Section 10. Section **31A-47-101** is enacted to read:
415 **CHAPTER 47. PRESCRIPTION DRUG PRICE TRANSPARENCY ACT**
416 **31A-47-101. Title.**
417 This chapter is known as "Prescription Drug Price Transparency Act."
418 Section 11. Section **31A-47-102** is enacted to read:
419 **31A-47-102. Definitions.**
420 As used in this chapter:
421 (1) "Drug" means a prescription drug, as defined in Section 58-17b-102.
422 (2) "Insurer" means the same as that term is defined in Section 31A-22-634.
423 (3) "Manufacturer" means a person that is engaged in the manufacturing of a drug that
424 is available for purchase by residents of the state.
425 (4) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C.
426 Sec. 1395w-3a.
427 Section 12. Section **31A-47-103** is enacted to read:
428 **31A-47-103. Manufacturer reports -- Insurer report -- Publication by department.**

429 (1) No later than January 15 of each year, a manufacturer shall report to the department
430 the current wholesale acquisition cost of drugs that are:
431 (a) manufactured by the manufacturer; and
432 (b) available for purchase by residents of the state.
433 (2) (a) A manufacturer of a drug shall report to the department the information
434 described in Subsection (2)(b) no more than 30 days after the day on which an increase to the
435 wholesale acquisition cost of the drug results in an increase to the wholesale acquisition cost of
436 the drug of:
437 (i) 40 percent or more over the preceding three years; or
438 (ii) 15 percent or more over the preceding twelve months.
439 (b) The manufacturer shall report:
440 (i) (A) the name of the drug;
441 (B) the dosage form of the drug; and
442 (C) the strength of the drug;
443 (ii) whether the drug is a brand name drug or a generic drug;
444 (iii) the effective date of the increase in the wholesale acquisition cost of the drug;
445 (iv) the factors that led to the increase in the wholesale acquisition cost of the drug and
446 the significance of each factor;
447 (v) the manufacturer's company-wide research and development costs for the most
448 recent year for which final audit data is available;
449 (vi) the name of each of the manufacturer's drugs approved by the United States Food
450 and Drug Administration during the preceding three calendar years; and
451 (vii) the names of drugs manufactured by the manufacturer that lost patent exclusivity
452 in the United States during the preceding three calendar years.
453 (c) Subsection (2)(a) applies only to a drug with a wholesale acquisition cost of at least
454 $100 for a 30-day supply before the effective date of the increase in the wholesale acquisition
455 cost of the drug.
456 (d) The quality and types of information that a manufacturer submits to the department
457 under Subsection (2)(a) shall be consistent with the quality and types of information the
458 manufacturer includes in:
459 (i) the manufacturer's annual consolidated report on Securities and Exchange

460 Commission Form 10-K; and
461 (ii) other public disclosures.
462 (3) No later than February 1 of each year, an insurer shall report to the department in
463 aggregate the following information for the preceding plan year for health benefit plans offered
464 by the insurer:
465 (a) for the 25 drugs for which the greatest number of claims were made:
466 (i) the name of the drug;
467 (ii) the dosage form of the drug; and
468 (iii) the strength of the drug;
469 (b) the percentage increase over the previous year in net spending for all drugs;
470 (c) the percentage of the increase in premiums over the previous year attributable to all
471 drugs;
472 (d) the percentage of specialty drugs with utilization management requirements; and
473 (e) the effect of specialty drug utilization management on premiums.
474 (4) The department shall publish on the department's website:
475 (a) no later than March 1 of each year, information reported to the department under
476 Subsection (1);
477 (b) no later than 60 days after receiving the information, information reported to the
478 department under Subsection (2); and
479 (c) no later than May 1 of each year, information reported to the department under
480 Subsection (3).