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℄ 03-14-19 5:06 PM ℄

H.B. 370
3rd Sub. (Cherry)

Senator Evan J. Vickers proposes the following substitute bill:

1 # PHARMACY BENEFIT MANAGER AMENDMENTS

2 2019 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Paul Ray**

5 Senate Sponsor: Evan J. Vickers

6 Cosponsors:
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8 Melissa G. Ballard
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18 **LONG TITLE**

19 **General Description:**

20 This bill amends and creates requirements for pharmacy benefit managers.

21 **Highlighted Provisions:**

22 This bill:

23 ▸ creates a pharmacy benefit manager license;

3rd Sub. H.B. 370

24 ▸ requires a person who acts as a pharmacy benefit manager in the state to be licensed
25 by the Insurance Department; and
26 ▸ creates certain operating and reporting requirements for pharmacy benefit managers.
27 **Money Appropriated in this Bill:**
28 None
29 **Other Special Clauses:**
30 This bill provides a special effective date.
31 **Utah Code Sections Affected:**
32 AMENDS:
33 **31A-2-201.2**, as last amended by Laws of Utah 2018, Chapter 319
34 ENACTS:
35 **31A-46-101**, Utah Code Annotated 1953
36 **31A-46-102**, Utah Code Annotated 1953
37 **31A-46-201**, Utah Code Annotated 1953
38 **31A-46-202**, Utah Code Annotated 1953
39 **31A-46-301**, Utah Code Annotated 1953
40 **31A-46-304**, Utah Code Annotated 1953
41 **31A-46-401**, Utah Code Annotated 1953
42 **31A-46-402**, Utah Code Annotated 1953
43 RENUMBERS AND AMENDS:
44 **31A-46-302**, (Renumbered from 58-17b-626, as enacted by Laws of Utah 2018,
45 Chapter 305)
46 **31A-46-303**, (Renumbered from 31A-22-640, as last amended by Laws of Utah 2015,
47 Chapter 258)
48

49 *Be it enacted by the Legislature of the state of Utah:*
50 Section 1. Section **31A-2-201.2** is amended to read:
51 **31A-2-201.2. Evaluation of health insurance market.**
52 (1) Each year the commissioner shall:
53 (a) conduct an evaluation of the state's health insurance market;
54 (b) report the findings of the evaluation to the Health and Human Services Interim

55 Committee before December 1 of each year; and
56 (c) publish the findings of the evaluation on the department website.
57 (2) The evaluation required by this section shall:
58 (a) analyze the effectiveness of the insurance regulations and statutes in promoting a
59 healthy, competitive health insurance market that meets the needs of the state, and includes an
60 analysis of:
61 (i) the availability and marketing of individual and group products;
62 (ii) rate changes;
63 (iii) coverage and demographic changes;
64 (iv) benefit trends;
65 (v) market share changes; and
66 (vi) accessibility;
67 (b) assess complaint ratios and trends within the health insurance market, which
68 assessment shall include complaint data from the Office of Consumer Health Assistance within
69 the department;
70 (c) contain recommendations for action to improve the overall effectiveness of the
71 health insurance market, administrative rules, and statutes; [~~and~~]
72 (d) include claims loss ratio data for each health insurance company doing business in
73 the state[~~.~~]; and
74 (e) include information about pharmacy benefit managers collected under Section
75 31A-46-301.
76 (3) When preparing the evaluation and report required by this section, the
77 commissioner may seek the input of insurers, employers, insured persons, providers, and others
78 with an interest in the health insurance market.
79 (4) The commissioner may adopt administrative rules for the purpose of collecting the
80 data required by this section, taking into account the business confidentiality of the insurers.
81 (5) Records submitted to the commissioner under this section shall be maintained by
82 the commissioner as protected records under Title 63G, Chapter 2, Government Records
83 Access and Management Act.
84 Section 2. Section **31A-46-101** is enacted to read:
85 **CHAPTER 46. PHARMACY BENEFIT MANAGER LICENSING ACT**

86 **Part 1. General Provisions**

87 **31A-46-101. Title.**

88 This chapter is known as the "Pharmacy Benefit Manager Licensing Act."

89 Section 3. Section **31A-46-102** is enacted to read:

90 **31A-46-102. Definitions.**

91 As used in this chapter:

92 (1) "Administrative fee" means any payment, other than a rebate, that a pharmaceutical

93 manufacturer makes directly or indirectly to a pharmacy benefit manager.

94 (2) "Contracting insurer" means an insurer as defined in Section 31A-22-636 with

95 whom a pharmacy benefit manager contracts to provide a pharmacy benefit management

96 service.

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

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

99 (5) "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)(a)
118 or (5)(b)(i) through (xii).
119 (6) "Pharmacy benefit manager" means a person licensed under this chapter to provide
120 a pharmacy benefit management service.
121 (7) "Pharmacy service" means a product, good, or service provided to an individual by
122 a pharmacy or pharmacist.
123 (8) (a) "Rebate" means a refund, discount, or other price concession that is paid by a
124 pharmaceutical manufacturer to a pharmacy benefit manager based on a prescription drug's
125 utilization or effectiveness.
126 (b) "Rebate" does not include an administrative fee.
127 Section 4. Section **31A-46-201** is enacted to read:
128 **Part 2. Licensure**
129 **31A-46-201. License required.**
130 (1) A person may not perform, offer to perform, or advertise any pharmacy benefits
131 management service in the state unless the person is licensed as a pharmacy benefit manager
132 under this chapter.
133 (2) A person may not utilize the services of another person as a pharmacy benefit
134 manager if the person knows or has reason to know that the other person does not have a
135 license under this chapter.
136 Section 5. Section **31A-46-202** is enacted to read:
137 **31A-46-202. Application for licensure.**
138 (1) To obtain or renew a license as a pharmacy benefit manager, a person shall:
139 (a) submit an application to the commissioner on forms and in a manner established by
140 the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
141 Rulemaking Act; and
142 (b) pay a licensure fee established by the department in accordance with Section
143 31A-3-103.
144 (2) (a) The commissioner may require an applicant to submit information or
145 documentation regarding the management and ownership of the pharmacy benefit manager in
146 the application described in Subsection (1)(a).
147 (b) Any material change in the information submitted in an application described in

148 Subsection (1)(a) shall be reported to the department within 30 days after the day on which the
149 information changes.
150 (3) The term of a license issued under this section is one year.
151 Section 6. Section **31A-46-301** is enacted to read:
152 **Part 3. Operating Requirements**
153 **31A-46-301. Reporting requirements.**
154 (1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall
155 report to the department, for the previous calendar year:
156 (a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit
157 manager had a contract;
158 (b) the total value, in the aggregate, of all rebates and administrative fees that are
159 attributable to enrollees of a contracting insurer; and
160 (c) the percentage of aggregate rebates that the pharmacy benefit manager retained
161 under the pharmacy benefit manager's agreement to provide pharmacy benefits management
162 services to a contracting insurer.
163 (2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a
164 protected record under Title 63G, Chapter 2, Government Records Access and Management
165 Act.
166 (3) (a) The department shall publish the information provided by a pharmacy benefit
167 manager under Subsection (1)(c) in the annual report described in Section 31A-2-201.2.
168 (b) The department may not publish information submitted under Subsection (1)(b) or
169 (c) in a manner that:
170 (i) makes a specific submission from a contracting insurer or pharmacy benefit
171 manager identifiable; or
172 (ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2.
173 (c) At least 30 days before the day on which the department publishes the data, the
174 department shall provide a pharmacy benefit manager that submitted data under Subsection
175 (1)(b) or (c) with:
176 (i) a general description of the data that will be published by the department;
177 (ii) an opportunity to submit to the department, within a reasonable period of time and
178 in a manner established by the department by rule made in accordance with Title 63G, Chapter

179 3, Utah Administrative Rulemaking Act:
180 (A) any correction of errors, with supporting evidence and comments; and
181 (B) information that demonstrates that the publication of the data will violate
182 Subsection (3)(b), with supporting evidence and comments.
183 Section 7. Section **31A-46-302**, which is renumbered from Section 58-17b-626 is
184 renumbered and amended to read:
185 **[~~58-17b-626~~]. 31A-46-302. Direct or indirect remuneration by pharmacy**
186 **benefit managers -- Disclosure of customer costs -- Limit on customer payment for**
187 **prescription drugs.**
188 (1) As used in this section:
189 (a) "Allowable claim amount" means the amount paid by an insurer under the
190 customer's health benefit plan.
191 [~~(a)~~] (b) "Cost share" means the amount paid by an insured customer under the
192 customer's health benefit plan.
193 [~~(b)~~] (c) "Direct or indirect remuneration" means any adjustment in the total
194 compensation:
195 (i) received by a pharmacy from a pharmacy [~~benefits manager or coordinator~~] benefit
196 manager for the sale of a drug, device, or other product or service; and
197 (ii) that is determined after the sale of the product or service.
198 [~~(c)~~] (d) "Health benefit plan" means the same as that term is defined in Section
199 31A-1-301.
200 (e) "Pharmacy reimbursement" means the amount paid to a pharmacy by a pharmacy
201 benefit manager for a dispensed prescription drug.
202 [~~(d)~~] (f) "Pharmacy services administration organization" means an entity that contracts
203 with a pharmacy to assist with third-party payer interactions and administrative services related
204 to third-party payer interactions, including:
205 (i) contracting with a pharmacy [~~benefits manager or coordinator~~] benefit manager on
206 behalf of the pharmacy; and
207 (ii) managing a pharmacy's claims payments from third-party payers.
208 [~~(e)~~] (g) "Pharmacy service entity" means:
209 (i) a pharmacy services administration organization; or

210 (ii) a pharmacy [~~benefits manager or coordinator~~] benefit manager.
211 [~~(f)~~] (h) (i) "Reimbursement report" means a report on the adjustment in total
212 compensation for a claim.
213 (ii) "Reimbursement report" does not include a report on adjustments made pursuant to
214 a pharmacy audit or reprocessing.
215 [~~(g)~~] (i) "Sale" means a prescription drug claim covered by a health benefit plan.
216 (2) If a pharmacy service entity engages in direct or indirect remuneration with a
217 pharmacy, the pharmacy service entity shall make a reimbursement report available to the
218 pharmacy upon the pharmacy's request.
219 (3) For the reimbursement report described in Subsection (2), the pharmacy service
220 entity shall:
221 (a) include the adjusted compensation amount related to a claim and the reason for the
222 adjusted compensation; and
223 (b) provide the reimbursement report:
224 (i) in accordance with the contract between the pharmacy and the pharmacy service
225 entity;
226 (ii) in an electronic format that is easily accessible; and
227 (iii) within 120 days after the day on which the pharmacy [~~benefits manager or~~
228 ~~coordinator~~] benefit manager receives a report of a sale of a product or service by the
229 pharmacy.
230 (4) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy
231 with:
232 (a) the reasons for any adjustments contained in a reimbursement report; and
233 (b) an explanation of the reasons provided in Subsection (4)(a).
234 (5) (a) A pharmacy [~~benefits manager or coordinator~~] benefit manager may not prohibit
235 or penalize the disclosure by a pharmacist of:
236 (i) an insured customer's cost share for a covered prescription drug;
237 (ii) the availability of any therapeutically equivalent alternative medications; or
238 (iii) alternative methods of paying for the prescription medication, including paying the
239 cash price, that are less expensive than the cost share of the prescription drug.
240 (b) Penalties that are prohibited under Subsection (5)(a) include increased utilization

241 review, reduced payments, and other financial disincentives.

242 (6) A pharmacy [~~benefits manager or coordinator~~] benefit manager may not require an

243 insured customer to pay, for a covered prescription drug, more than the lesser of:

244 (a) the applicable cost share of the prescription drug being dispensed; [~~or~~]

245 (b) the applicable allowable claim amount of the prescription drug being dispensed;

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

247 [~~(b)~~] (d) the retail price of the drug without prescription drug coverage.

248 Section 8. Section **31A-46-303**, which is renumbered from Section 31A-22-640 is

249 renumbered and amended to read:

250 **[~~31A-22-640~~]. 31A-46-303. Insurer and pharmacy benefit management**

251 **services -- Registration -- Maximum allowable cost -- Audit restrictions.**

252 (1) [~~For purposes of~~] As used in this section:

253 (a) "Maximum allowable cost" means:

254 (i) a maximum reimbursement amount for a group of pharmaceutically and

255 therapeutically equivalent drugs; or

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

257 reimburse pharmacies for multiple source drugs.

258 (b) "Obsolete" means a product that may be listed in national drug pricing compendia

259 but is no longer available to be dispensed based on the expiration date of the last lot

260 manufactured.

261 (c) " Pharmacy benefit manager" means a person or entity that provides pharmacy

262 benefit management services as defined in Section 49-20-502 on behalf of an insurer as defined

263 in Subsection 31A-22-636(1).

264 (2) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy

265 audit provisions of Section 58-17b-622.

266 (3) A pharmacy benefit manager shall not use maximum allowable cost as a basis for

267 reimbursement to a pharmacy unless:

268 (a) the drug is listed as "A" or "B" rated in the most recent version of the United States

269 Food and Drug Administration's approved drug products with therapeutic equivalent

270 evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating

271 by a nationally recognized reference; and

272 (b) the drug is:
273 (i) generally available for purchase in this state from a national or regional wholesaler;
274 and
275 (ii) not obsolete.
276 (4) The maximum allowable cost may be determined using comparable and current
277 data on drug prices obtained from multiple nationally recognized, comprehensive data sources,
278 including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are
279 available for purchase by pharmacies in the state.
280 (5) For every drug for which the pharmacy benefit manager uses maximum allowable
281 cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall:
282 (a) include in the contract with the pharmacy information identifying the national drug
283 pricing compendia and other data sources used to obtain the drug price data;
284 (b) review and make necessary adjustments to the maximum allowable cost, using the
285 most recent data sources identified in Subsection (5)(a), at least once per week;
286 (c) provide a process for the contracted pharmacy to appeal the maximum allowable
287 cost in accordance with Subsection (6); and
288 (d) include in each contract with a contracted pharmacy a process to obtain an update
289 to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily
290 available and accessible.
291 (6) (a) The right to appeal in Subsection (5)(c) shall be:
292 (i) limited to 21 days following the initial claim adjudication; and
293 (ii) investigated and resolved by the pharmacy benefit manager within 14 business
294 days.
295 (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted
296 pharmacy with the reason for the denial and the identification of the national drug code of the
297 drug that may be purchased by the pharmacy at a price at or below the price determined by the
298 pharmacy benefit manager.
299 (7) The contract with each pharmacy shall contain a dispute resolution mechanism in
300 the event either party breaches the terms or conditions of the contract.
301 [~~(8) (a) To conduct business in the state, a pharmacy benefit manager shall register~~
302 ~~with the Division of Corporations and Commercial Code within the Department of Commerce~~

303 and annually renew the registration. To register under this section, the pharmacy benefit
304 manager shall submit an application which shall contain only the following information:]
305 [(i) the name of the pharmacy benefit manager;]
306 [(ii) the name and contact information for the registered agent for the pharmacy benefit
307 manager; and]
308 [(iii) if applicable, the federal employer identification number for the pharmacy benefit
309 manager.]
310 [(b) The Department of Commerce may establish a fee in accordance with Title 63J,
311 Chapter 1, Budgetary Procedures Act, for the initial registration and the annual renewal of the
312 registration, which may not exceed $100 per year.]
313 [(c) The following entities do not have to register as a pharmacy benefit manager under
314 Subsection (8)(a) when the entity is providing formulary services to its own patients,
315 employees, members, or beneficiaries:]
316 [(i) a health care facility licensed under Title 26, Chapter 21, Health Care Facility
317 Licensing and Inspection Act;]
318 [(ii) a pharmacy licensed under Title 58, Chapter 17b, Pharmacy Practice Act;]
319 [(iii) a health care professional licensed under Title 58, Occupations and Professions;]
320 [(iv) a health insurer; and]
321 [(v) a labor union.]
322 [(9)] (8) This section does not apply to a pharmacy benefit manager when the
323 pharmacy benefit manager is providing pharmacy benefit management services on behalf of the
324 state Medicaid program.
325 Section 9. Section **31A-46-304** is enacted to read:
326 **31A-46-304. Claims practices.**
327 (1) A pharmacy benefit manager shall permit a pharmacy to collect the amount of a
328 customer's cost share from any source.
329 (2) A pharmacy benefit manager may not deny or reduce a reimbursement to a
330 pharmacy or a pharmacist after the adjudication of the claim, unless:
331 (a) the pharmacy or pharmacist submitted the original claim fraudulently;
332 (b) the original reimbursement was incorrect because:
333 (i) the pharmacy or pharmacist had already been paid for the pharmacy service; or

334 (ii) an unintentional error resulted in an incorrect reimbursement; or
335 (c) the pharmacy service was not rendered by the pharmacy or pharmacist.
336 (3) Subsection (2) does not apply if:
337 (a) an investigative audit of pharmacy records for fraud, waste, abuse, or other
338 intentional misrepresentation indicates that the pharmacy or pharmacist engaged in criminal
339 wrongdoing, fraud, or other intentional misrepresentation; or
340 (b) the reimbursement is reduced as the result of the reconciliation of a reimbursement
341 amount under a performance contract if:
342 (i) the performance contract lays out clear performance standards under which the
343 reimbursement for a specific drug may be increased or decreased; and
344 (ii) the agreement between the pharmacy benefit manager and the pharmacy or
345 pharmacist explicitly states, in a separate document that is signed by the pharmacy benefit
346 manager and the pharmacy or pharmacist, that the provisions of Subsection (2) do not apply.
347 Section 10. Section **31A-46-401** is enacted to read:
348 **Part 4. Miscellaneous**
349 **31A-46-401. Penalties.**
350 A person that violates a provision of this chapter is subject to the penalties described in
351 Section 31A-2-308.
352 Section 11. Section **31A-46-402** is enacted to read:
353 **31A-46-402. Severability.**
354 If any provision of this chapter or the application of any provision of this chapter is
355 found invalid, the remainder of this chapter shall be given effect without the invalid provision
356 or application.
357 Section 12. **Effective date.**
358 This bill takes effect on July 1, 2019.