

PHARMACY BENEFIT MANAGER REVISIONS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Evan J. Vickers

House Sponsor: Steve Eliason

LONG TITLE

General Description:

This bill amends provisions relating to pharmacy benefit managers.

Highlighted Provisions:

This bill:

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

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a coordination clause.

Utah Code Sections Affected:

AMENDS:

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

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

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

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

32 ENACTS:

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

34 **Utah Code Sections Affected by Coordination Clause:**

35 **31A-46-302**, as renumbered and amended by Laws of Utah 2019, Chapter 241

36

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

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

39 **26-18-405. Waivers to maximize replacement of fee-for-service delivery model --**
40 **Cost of mandated program changes.**

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

43 (2) The waiver program shall:

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

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

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

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

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

55 (i) pay providers for packages of services delivered over entire episodes of illness

56 rather than for individual services delivered during each patient encounter; and

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

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

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

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

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

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

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

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

83 which the managed care organization or pharmacy benefit manager provides a pharmacy
84 benefit.

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

86 **31A-46-102. Definitions.**

87 As used in this chapter:

88 (1) "340B drug" means a drug purchased through the 340B drug discount program by a
89 340B entity.

90 (2) "340B drug discount program" means the 340B drug discount program described in
91 42 U.S.C. Sec. 256b.

92 (3) "340B entity" means:

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

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

95 (c) a pharmacy contracting with an entity participating in the 340B drug discount
96 program to dispense drugs purchased through the 340B drug discount program.

97 ~~[(+)]~~ (4) "Administrative fee" means any payment, other than a rebate, that a
98 pharmaceutical manufacturer makes directly or indirectly to a pharmacy benefit manager.

99 (5) "Allowable claim amount" means the amount paid by an insurer under the
100 customer's health benefit plan.

101 ~~[(2)]~~ (6) "Contracting insurer" means an insurer ~~[as defined in Section 31A-22-636]~~
102 with whom a pharmacy benefit manager contracts to provide a pharmacy benefit management
103 service.

104 (7) "Cost share" means the amount paid by an insured customer under the customer's
105 health benefit plan.

106 (8) "Direct or indirect remuneration" means any adjustment in the total compensation:

107 (a) received by a pharmacy from a pharmacy benefit manager for the sale of a drug,

108 device, or other product or service; and

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

- 110 (9) "Drug" means the same as that term is defined in Section 58-17b-102.
- 111 (10) "Insurer" means the same as that term is defined in Section 31A-22-636.
- 112 (11) "Maximum allowable cost" means:
- 113 (a) a maximum reimbursement amount for a group of pharmaceutically and
- 114 therapeutically equivalent drugs; or
- 115 (b) any similar reimbursement amount that is used by a pharmacy benefit manager to
- 116 reimburse pharmacies for multiple source drugs.
- 117 (12) "Medicaid program" means the same as that term is defined in Section 26-18-2.
- 118 (13) "Obsolete" means a product that may be listed in national drug pricing compendia
- 119 but is no longer available to be dispensed based on the expiration date of the last lot
- 120 manufactured.
- 121 ~~[(3)]~~ (14) "Pharmacist" means the same as that term is defined in Section 58-17b-102.
- 122 ~~[(4)]~~ (15) "Pharmacy" means the same as that term is defined in Section 58-17b-102.
- 123 ~~[(5)]~~ (16) "Pharmacy benefits management service" means any of the following
- 124 services provided to a health benefit plan, or to a participant of a health benefit plan:
- 125 (a) negotiating the amount to be paid by a health benefit plan for a prescription drug; or
- 126 (b) administering or managing a prescription drug benefit provided by the health
- 127 benefit plan for the benefit of a participant of the health benefit plan, including administering
- 128 or managing:
- 129 (i) ~~[a]~~ an out-of-state mail service pharmacy;
- 130 (ii) a specialty pharmacy;
- 131 (iii) claims processing;
- 132 (iv) payment of a claim;
- 133 (v) retail network management;
- 134 (vi) clinical formulary development;
- 135 (vii) clinical formulary management services;
- 136 (viii) rebate contracting;

- 137 (ix) rebate administration;
- 138 (x) a participant compliance program;
- 139 (xi) a therapeutic intervention program;
- 140 (xii) a disease management program; or
- 141 (xiii) a service that is similar to, or related to, a service described in Subsection ~~[(5)]~~
- 142 ~~(16)(a)~~ or ~~[(5)]~~ ~~(16)(b)(i)~~ through (xii).

143 ~~[(6)]~~ (17) "Pharmacy benefit manager" means a person licensed under this chapter to
144 provide a pharmacy benefits management service.

145 ~~[(7)]~~ (18) "Pharmacy service" means a product, good, or service provided to an
146 individual by a pharmacy or pharmacist.

147 (19) "Pharmacy services administration organization" means an entity that contracts
148 with a pharmacy to assist with third-party payer interactions and administrative services related
149 to third-party payer interactions, including:

- 150 (a) contracting with a pharmacy benefit manager on behalf of the pharmacy; and
- 151 (b) managing a pharmacy's claims payments from third-party payers.

152 (20) "Pharmacy service entity" means:

- 153 (a) a pharmacy services administration organization; or
- 154 (b) a pharmacy benefit manager.

155 (21) "Prescription device" means the same as that term is defined in Section
156 [58-17b-102](#).

157 ~~[(8)]~~ (22) (a) "Rebate" means a refund, discount, or other price concession that is paid
158 by a pharmaceutical manufacturer to a pharmacy benefit manager based on a prescription
159 drug's utilization or effectiveness.

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

161 (23) (a) "Reimbursement report" means a report on the adjustment in total
162 compensation for a claim.

163 (b) "Reimbursement report" does not include a report on adjustments made pursuant to

164 a pharmacy audit or reprocessing.

165 (24) "Sale" means a prescription drug or prescription device claim covered by a health
166 benefit plan.

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

168 **31A-46-302. Direct or indirect remuneration by pharmacy benefit managers --**
169 **Disclosure of customer costs -- Limit on customer payment for prescription drugs.**

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

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

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

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

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

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

180 [~~(d) "Health benefit plan" means the same as that term is defined in Section~~
181 ~~31A-1-301.]~~

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

184 [~~(f) "Pharmacy services administration organization" means an entity that contracts~~
185 ~~with a pharmacy to assist with third-party payer interactions and administrative services related~~
186 ~~to third-party payer interactions, including:]~~

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

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

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

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

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

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

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

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

197 ~~[(2)]~~ (1) If a pharmacy service entity engages in direct or indirect remuneration with a
198 pharmacy, the pharmacy service entity shall make a reimbursement report available to the
199 pharmacy upon the pharmacy's request.

200 ~~[(3)]~~ (2) For the reimbursement report described in Subsection ~~[(2)]~~ (1), the pharmacy
201 service entity shall:

202 (a) include the adjusted compensation amount related to a claim and the reason for the
203 adjusted compensation; and

204 (b) provide the reimbursement report:

205 (i) in accordance with the contract between the pharmacy and the pharmacy service
206 entity;

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

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

210 ~~[(4)]~~ (3) A pharmacy service entity shall, upon a pharmacy's request, provide the
211 pharmacy with:

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

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

214 ~~[(5)]~~ (4) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by
215 a pharmacist of:

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

217 (ii) the availability of any therapeutically equivalent alternative medications; or

218 (iii) alternative methods of paying for the prescription medication, including paying the
219 cash price, that are less expensive than the cost share of the prescription drug.

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

222 ~~[(6)]~~ (5) A pharmacy benefit manager may not require an insured customer to pay, for a
223 covered prescription drug, more than the lesser of:

- 224 (a) the applicable cost share of the prescription drug being dispensed;
- 225 (b) the applicable allowable claim amount of the prescription drug being dispensed;
- 226 (c) the applicable pharmacy reimbursement of the prescription drug being dispensed; or
- 227 (d) the retail price of the drug without prescription drug coverage.

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

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

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

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

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

235 (b) charge an enrollee who uses an in-network retail pharmacy that offers to mail or
236 deliver a prescription drug to an enrollee a fee or copayment that is higher than the fee or
237 copayment the enrollee would pay if the enrollee used an in-network retail pharmacy that does
238 not offer to mail or deliver a prescription drug to an enrollee.

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

240 **31A-46-303. Insurer and pharmacy benefit management services -- Registration**
241 **-- Maximum allowable cost -- Audit restrictions.**

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

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

244 ~~[(i) a maximum reimbursement amount for a group of pharmaceutically and~~

245 therapeutically equivalent drugs; or]

246 [(ii) any similar reimbursement amount that is used by a pharmacy benefit manager to
247 reimburse pharmacies for multiple source drugs.]

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

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

254 [(2)] (1) An insurer and an insurer's pharmacy benefit manager is subject to the
255 pharmacy audit provisions of Section ~~58-17b-622~~.

256 [(3)] (2) A pharmacy benefit manager shall not use maximum allowable cost as a basis
257 for reimbursement to a pharmacy unless:

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

262 (b) the drug is:

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

264 and

265 (ii) not obsolete.

266 [(4)] (3) The maximum allowable cost may be determined using comparable and
267 current data on drug prices obtained from multiple nationally recognized, comprehensive data
268 sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs
269 that are available for purchase by pharmacies in the state.

270 [(5)] (4) For every drug for which the pharmacy benefit manager uses maximum
271 allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall:

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

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

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

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

281 [~~(6)~~] (5) (a) The right to appeal in Subsection [~~(5)~~] (4)(c) shall be:

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

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

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

289 [~~(7)~~] (6) The contract with each pharmacy shall contain a dispute resolution mechanism
290 in the event either party breaches the terms or conditions of the contract.

291 [~~(8)~~] (7) This section does not apply to a pharmacy benefit manager when the
292 pharmacy benefit manager is providing pharmacy benefit management services on behalf of the
293 [state] Medicaid program.

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

295 **31A-46-305. Reimbursement -- Prohibitions.**

296 (1) This section applies to a contract entered into or renewed on or after January 1,
297 2021, between a pharmacy benefit manager and a pharmacy.

298 (2) A pharmacy benefit manager may not vary the amount it reimburses a pharmacy for

299 a drug on the basis of whether:

300 (a) the drug is a 340B drug; or

301 (b) the pharmacy is a 340B entity.

302 (3) Subsection (2) does not apply to a drug reimbursed, directly or indirectly, by the
303 Medicaid program.

304 (4) A pharmacy benefit manager may not:

305 (a) on the basis that a 340B entity participates, directly or indirectly, in the 340B drug
306 discount program:

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

308 (ii) restrict access to the pharmacy benefit manager's pharmacy network;

309 (iii) require the 340B entity to enter into a contract with a specific pharmacy to
310 participate in the pharmacy benefit manager's pharmacy network;

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

313 (v) create any additional requirements or restrictions on the 340B entity; or

314 (b) require a claim for a drug to include a modifier to indicate that the drug is a 340B
315 drug unless the claim is for payment, directly or indirectly, by the Medicaid program.

316 **Section 6. Coordinating S.B. 138 with H.B. 272 -- Omitting substantive changes.**

317 If this S.B. 138 and H.B. 272, Pharmacy Benefit Amendments, both pass and become
318 law, it is the intent of the Legislature that the Office of Legislative Research and General
319 Counsel, in preparing the Utah Code database for publication, not enact Subsection
320 [31A-46-302\(6\)](#) in S.B. 138.