Norman K Thurston proposes the following substitute bill:

1 **Pharmacy Benefit Amendments**

2025 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Norman K Thurston

Senate Sponsor:

2

3 **LONG TITLE**

4 **General Description:**

5 This bill amends provisions related to health insurance pharmacy benefits.

6 **Highlighted Provisions:**

7 This bill:

8 ▸ defines terms;

9 ▸ requires the commissioner of the Insurance Department to assist in creating a form if
10 requested;

11 ▸ requires a health benefit plan to ensure pharmaceutical rebates are used for certain
12 purposes; and

13 ▸ requires a pharmacy benefit manager to offer certain options to self-funded health benefit
14 plans.

15 **Money Appropriated in this Bill:**

16 None

17 **Other Special Clauses:**

18 None

19 **Utah Code Sections Affected:**

20 AMENDS:

21 **31A-2-212**, as last amended by Laws of Utah 2020, Chapter 32

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

23 **31A-46-102**, as last amended by Laws of Utah 2020, Chapters 198, 275 and 372

24 ENACTS:

25 **31A-46-311**, Utah Code Annotated 1953

26

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

28 Section 1. Section **31A-2-212** is amended to read:

29 **31A-2-212 . Miscellaneous duties.**
30 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to do
31 business in Utah, and when the commissioner begins a proceeding against an insurer
32 under Chapter 27a, Insurer Receivership Act, the commissioner:
33 (a) shall notify by mail the producers of the person or insurer of whom the commissioner
34 has record; and
35 (b) may publish notice of the order or proceeding in any manner the commissioner
36 considers necessary to protect the rights of the public.
37 (2)(a) When required for evidence in a legal proceeding, the commissioner shall furnish
38 a certificate of authority of a licensee to transact the business of insurance in Utah on
39 any particular date.
40 (b) The court or other officer shall receive a certificate of authority described in this
41 Subsection (2) in lieu of the commissioner's testimony.
42 (3)(a) On the request of an insurer authorized to do a surety business, the commissioner
43 shall furnish a copy of the insurer's certificate of authority to a designated public
44 officer in this state who requires that certificate of authority before accepting a bond.
45 (b) The public officer described in Subsection (3)(a) shall file the certificate of authority
46 furnished under Subsection (3)(a).
47 (c) After a certified copy of a certificate of authority is furnished to a public officer, it is
48 not necessary, while the certificate of authority remains effective, to attach a copy of
49 it to any instrument of suretyship filed with that public officer.
50 (d) Whenever the commissioner revokes the certificate of authority or begins a
51 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer
52 authorized to do a surety business, the commissioner shall immediately give notice of
53 that action to each public officer who is sent a certified copy under this Subsection (3).
54 (4)(a) The commissioner shall immediately notify every judge and clerk of the courts of
55 record in the state when:
56 (i) an authorized insurer doing a surety business:
57 (A) files a petition for receivership; or
58 (B) is in receivership; or
59 (ii) the commissioner has reason to believe that the authorized insurer doing surety
60 business:
61 (A) is in financial difficulty; or
62 (B) has unreasonably failed to carry out any of the authorized insurer's contracts.

63 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the
64 judges and clerks to notify and require a person that files with the court a bond on
65 which the authorized insurer doing surety business is surety to immediately file a new
66 bond with a new surety.
67 (5)(a) The commissioner shall require an insurer that issues, sells, renews, or offers
68 health insurance coverage in this state to comply with PPACA and administrative
69 rules adopted by the commissioner related to regulation of health benefit plans,
70 including:
71 (i) lifetime and annual limits;
72 (ii) prohibition of rescissions;
73 (iii) coverage of preventive health services;
74 (iv) coverage for a child or dependent;
75 (v) pre-existing condition limitations;
76 (vi) insurer transparency of consumer information including plan disclosures,
77 uniform coverage documents, and standard definitions;
78 (vii) premium rate reviews;
79 (viii) essential health benefits;
80 (ix) provider choice;
81 (x) waiting periods;
82 (xi) appeals processes;
83 (xii) rating restrictions;
84 (xiii) uniform applications and notice provisions;
85 (xiv) certification and regulation of qualified health plans; and
86 (xv) network adequacy standards.
87 (b) The commissioner shall preserve state control over:
88 (i) the health insurance market in the state;
89 (ii) qualified health plans offered in the state; and
90 (iii) the conduct of navigators, producers, and in-person assisters operating in the
91 state.
92 (6) If requested by an association that represents pharmacies or pharmacists, the
93 commissioner shall assist the association in developing a form that outlines a pharmacy's
94 rights under state and federal law related to pharmacy benefits, pharmacy benefit
95 managers, and health benefit plans.
96 Section 2. Section **31A-22-643** is amended to read:

97 **31A-22-643 . Prescription synchronization -- Copay and dispensing fee**
98 **restrictions -- Rebate requirements -- Pharmacy networks.**
99 (1) For purposes of this section:
100 (a) "Administrative fee" means the same as that term is defined in Section 31A-46-102.
101 (b) "Copay" means the copay normally charged for a prescription drug.
102 [~~(b)~~] (c) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).
103 [~~(c)~~] (d) "Network pharmacy" means a pharmacy included in a health insurance plan's
104 network of pharmacy providers.
105 (e) "Pharmacy benefit manager" means the same as that term is defined in Section
106 31A-46-102.
107 [~~(d)~~] (f) "Prescription drug" means a prescription drug, as defined in Section 58-17b-102,
108 that is prescribed for a chronic condition.
109 (g) "Rebate" means the same as that term is defined in Section 31A-46-102.
110 (h) "Standard rebate amount" means a rebate amount that:
111 (i) is estimated and set by a health benefit plan for a drug product;
112 (ii) adjusts each quarter based on rebate underpayments or overpayments; and
113 (iii) is applied when the drug product is dispensed.
114 (2) A health insurance plan may not charge an amount in excess of the copay for the
115 dispensing of a prescription drug in a quantity less than the prescribed amount if:
116 (a) the pharmacy dispenses the prescription drug in accordance with the health insurer's
117 synchronization policy; and
118 (b) the prescription drug is dispensed by a network pharmacy.
119 (3) A health insurance plan that includes a prescription drug benefit:
120 (a) shall implement a synchronization policy for the dispensing of prescription drugs to
121 the plan's enrollees; and
122 (b) may not base the dispensing fee for an individual prescription on the quantity of the
123 prescription drug dispensed to fill or refill the prescription unless otherwise agreed to
124 by the plan and the contracted pharmacy at the time the individual requests
125 synchronization.
126 (4) [~~This section applies to health benefit plans renewed or entered into on or after January~~
127 ~~1, 2015.~~]
128 (a) A health benefit plan shall ensure that each pharmaceutical manufacturer rebate is
129 used exclusively to benefit enrollees using one or multiple of the following methods:
130 (i) passing down the rebate to the point of sale to offset an enrollee's deductible or

131 coinsurance;
132 (ii) using the rebate to reduce premiums paid by the enrollee; or
133 (iii) using the rebate to enhance enrollee health benefits.
134 (b) When passing down a rebate as described in Subsection (4)(a)(i), a health benefit
135 plan may:
136 (i) divide the rebate between the health benefit plan and the enrollee in a manner that
137 is proportional to the enrollee's payment obligation; or
138 (ii) use a standard rebate amount.
139 (5) A health benefit plan may not prohibit or condition participation in one pharmacy
140 network on participation in another pharmacy network.
141 (6) Subsections (4) and (5) apply to a health benefit plan renewed or entered into on or after
142 July 1, 2026.
143 Section 3. Section **31A-46-102** is amended to read:
144 **31A-46-102 . Definitions.**
145 As used in this chapter:
146 (1) "340B drug" means a drug purchased through the 340B drug discount program by a
147 340B entity.
148 (2) "340B drug discount program" means the 340B drug discount program described in 42
149 U.S.C. Sec. 256b.
150 (3) "340B entity" means:
151 (a) an entity participating in the 340B drug discount program;
152 (b) a pharmacy of an entity participating in the 340B drug discount program; or
153 (c) a pharmacy contracting with an entity participating in the 340B drug discount
154 program to dispense drugs purchased through the 340B drug discount program.
155 (4) "Administrative fee" means any payment, other than a rebate, that a pharmaceutical
156 manufacturer makes directly or indirectly to a pharmacy benefit manager.
157 (5) "Allowable claim amount" means the amount paid by an insurer under the customer's
158 health benefit plan.
159 (6) "Contracting insurer" means an insurer with whom a pharmacy benefit manager
160 contracts to provide a pharmacy benefit management service.
161 (7) "Cost share" means the amount paid by an insured customer under the customer's health
162 benefit plan.
163 [~~(8) "Device" means the same as that term is defined in Section 58-17b-102.~~]
164 [~~(9)~~] (8) "Direct or indirect remuneration" means any adjustment in the total compensation:

165 (a) received by a pharmacy from a pharmacy benefit manager for the sale of a drug,
166 device, or other product or service; and
167 (b) that is determined after the sale of the product or service.
168 [(10)] (9) "Dispense" means the same as that term is defined in Section 58-17b-102.
169 [(11)] (10) "Drug" means the same as that term is defined in Section 58-17b-102.
170 [(12)] (11) "Insurer" means the same as that term is defined in Section 31A-22-636.
171 [(13)] (12) "Maximum allowable cost" means:
172 (a) a maximum reimbursement amount for a group of pharmaceutically and
173 therapeutically equivalent drugs; or
174 (b) any similar reimbursement amount that is used by a pharmacy benefit manager to
175 reimburse pharmacies for multiple source drugs.
176 [(14)] (13) "Medicaid program" means the same as that term is defined in Section 26B-3-101.
177 [(15)] (14) "Obsolete" means a product that may be listed in national drug pricing
178 compendia but is no longer available to be dispensed based on the expiration date of the
179 last lot manufactured.
180 [(16)] (15) "Patient counseling" means the same as that term is defined in Section
181 58-17b-102.
182 [(17)] (16) "Pharmaceutical facility" means the same as that term is defined in Section
183 58-17b-102.
184 [(18)] (17) "Pharmaceutical manufacturer" means a pharmaceutical facility that
185 manufactures prescription drugs.
186 [(19)] (18) "Pharmacist" means the same as that term is defined in Section 58-17b-102.
187 [(20)] (19) "Pharmacy" means the same as that term is defined in Section 58-17b-102.
188 [(21)] (20) "Pharmacy benefits management service" means any of the following services
189 provided to a health benefit plan, or to a participant of a health benefit plan:
190 (a) negotiating the amount to be paid by a health benefit plan for a prescription drug; or
191 (b) administering or managing a prescription drug benefit provided by the health benefit
192 plan for the benefit of a participant of the health benefit plan, including administering
193 or managing:
194 (i) an out-of-state mail service pharmacy;
195 (ii) a specialty pharmacy;
196 (iii) claims processing;
197 (iv) payment of a claim;
198 (v) retail network management;

199 (vi) clinical formulary development;
200 (vii) clinical formulary management services;
201 (viii) rebate contracting;
202 (ix) rebate administration;
203 (x) a participant compliance program;
204 (xi) a therapeutic intervention program;
205 (xii) a disease management program; or
206 (xiii) a service that is similar to, or related to, a service described in Subsection [
207 ~~(21)(a) or (21)(b)(i) through (xii).~~] <u>(20)(a) or this Subsection (20)(b).</u>
208 [~~(22)~~] <u>(21)</u> "Pharmacy benefit manager" means a person licensed under this chapter to
209 provide a pharmacy benefits management service.
210 [~~(23)~~] <u>(22)</u> "Pharmacy service" means a product, good, or service provided to an individual
211 by a pharmacy or pharmacist.
212 [~~(24)~~] <u>(23)</u> "Pharmacy services administration organization" means an entity that contracts
213 with a pharmacy to assist with third-party payer interactions and administrative services
214 related to third-party payer interactions, including:
215 (a) contracting with a pharmacy benefit manager on behalf of the pharmacy; and
216 (b) managing a pharmacy's claims payments from third-party payers.
217 [~~(25)~~] <u>(24)</u> "Pharmacy service entity" means:
218 (a) a pharmacy services administration organization; or
219 (b) a pharmacy benefit manager.
220 [~~(26)~~] <u>(25)</u> "Prescription device" means the same as that term is defined in Section
221 58-17b-102.
222 [~~(27)~~] <u>(26)</u> "Prescription drug" means the same as that term is defined in Section 58-17b-102.
223 [~~(28)~~] <u>(27)</u>(a) "Rebate" means a refund, discount, or other price concession that is paid by
224 a pharmaceutical manufacturer to a pharmacy benefit manager based on a
225 prescription drug's utilization or effectiveness.
226 (b) "Rebate" does not include an administrative fee.
227 [~~(29)~~] <u>(28)</u>(a) "Reimbursement report" means a report on the adjustment in total
228 compensation for a claim.
229 (b) "Reimbursement report" does not include a report on adjustments made pursuant to a
230 pharmacy audit or reprocessing.
231 [~~(30)~~] <u>(29)</u> "Retail pharmacy" means the same as that term is defined in Section 58-17b-102.
232 [~~(31)~~] <u>(30)</u> "Sale" means a prescription drug or prescription device claim covered by a

233 health benefit plan.
234 (31) "Spread pricing" means the practice in which a pharmacy benefit manager charges a
235 health benefit plan a different amount for pharmacist services than the amount the
236 pharmacy benefit manager reimburses a pharmacy for pharmacist services.
237 (32) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C. Sec.
238 1395w-3a.
239 Section 4. Section **31A-46-311** is enacted to read:
240 **31A-46-311 . Options for self-funded health benefit plans.**
241 A pharmacy benefit manager shall offer to a self-funded health benefit plan, as an option
242 for the self-funded health benefit plan's design, pharmacy benefit management services that:
243 (1) comply with the provisions of Subsections 31A-22-643(4) and (5), collectively and
244 individually; and
245 (2) do not include spread pricing.
246 Section 5. **Effective Date.**
247 This bill takes effect on May 7, 2025.