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H.B. 425

HEALTH INSURANCE BENEFIT AMENDMENTS

2024 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Norman K Thurston

Senate Sponsor: _____

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 pharmacy benefit manger to pass through pharmaceutical rebates to health benefit plans;
- requires a health benefit plan to ensure pharmaceutical rebates are used for certain purposes;
- enacts provisions related to network requirements for pharmacy benefit managers; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

H.B. 425

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-46-301, as last amended by Laws of Utah 2020, Chapter 198

ENACTS:

31A-46-311, Utah Code Annotated 1953

31A-46-312, Utah Code Annotated 1953

REPEALS:

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

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.

(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.

(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.~~] In accordance with Section 31A-46-311, a health benefit plan shall ensure that any rebate, as defined in Section 31A-46-102, is:

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

(b) if the enrollee does not have any cost sharing described in Subsection (4)(a), used to reduce premiums.

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)~~] (b) 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)~~] (b) 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.~~]

[~~(5)~~] (4) "Allowable claim amount" means the amount paid by an insurer under the customer's health benefit plan.

[~~(6)~~] (5) "Contracting insurer" means an insurer with whom a pharmacy benefit manager contracts to provide a pharmacy benefit management service.

[~~(7)~~] (6) "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)~~] (7) "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)~~] (8) "Dispense" means the same as that term is defined in Section 58-17b-102.

[~~(11)~~] (9) "Drug" means the same as that term is defined in Section 58-17b-102.

[~~(12)~~] (10) "Insurer" means the same as that term is defined in Section 31A-22-636.

[~~(13)~~] (11) "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)~~] (12) "Medicaid program" means the same as that term is defined in Section 26B-3-101.

[~~(15)~~] (13) "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)~~] (14) "Patient counseling" means the same as that term is defined in Section 58-17b-102.

[~~(17)~~] (15) "Pharmaceutical facility" means the same as that term is defined in Section 58-17b-102.

[~~(18)~~] (16) "Pharmaceutical manufacturer" means a pharmaceutical facility that manufactures prescription drugs.

[~~(19)~~] (17) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

[~~(20)~~] (18) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(21)~~] (19) "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)~~] (19)(a) or [~~(21)(b)(i) through (xii).~~] this Subsection (19)(b).

[~~(22)~~] (20) "Pharmacy benefit manager" means a person licensed under this chapter to provide a pharmacy benefits management service.

[~~(23)~~] (21) "Pharmacy service" means a product, good, or service provided to an individual by a pharmacy or pharmacist.

[~~(24)~~] (22) "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)~~] (23) "Pharmacy service entity" means:

(a) a pharmacy services administration organization; or

(b) a pharmacy benefit manager.

[~~(26)~~] (24) "Prescription device" means the same as that term is defined in Section 58-17b-102.

[~~(27)~~] (25) "Prescription drug" means the same as that term is defined in Section 58-17b-102.

[~~(28)~~] (26) (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~~] includes any discount, administrative fee, credit, incentive, or penalty associated directly or indirectly in any way with a claim administered on behalf of a health benefit plan.

[~~(29)~~] (27) (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)~~] (28) "Retail pharmacy" means the same as that term is defined in Section 58-17b-102.

[~~(31)~~] (29) "Sale" means a prescription drug or prescription device claim covered by a health benefit plan.

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

Section 6. Section **31A-46-301** is amended to read:

31A-46-301. Reporting requirements.

(1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall report to the department, for the previous calendar year:

(a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit manager had a contract;

(b) the total value, in the aggregate, of all rebates [~~and administrative fees~~] that are attributable to enrollees of a contracting insurer; and

(c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer.

(2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(3) (a) The department shall publish the information provided by a pharmacy benefit manager under Subsection (1)(c) in the annual report described in Section 31A-2-201.2.

(b) The department may not publish information submitted under Subsection (1)(b) or (c) in a manner that:

(i) makes a specific submission from a contracting insurer or pharmacy benefit manager identifiable; or

(ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2.

(c) At least 30 days before the day on which the department publishes the data, the department shall provide a pharmacy benefit manager that submitted data under Subsection (1)(b) or (c) with:

(i) a general description of the data that will be published by the department; and

(ii) an opportunity to submit to the department, within a reasonable period of time and in a manner established by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(A) any correction of errors, with supporting evidence and comments; and

(B) information that demonstrates that the publication of the data will violate Subsection (3)(b), with supporting evidence and comments.

Section 7. Section **31A-46-311** is enacted to read:

31A-46-311. Pass down requirements for rebates -- Spread pricing option.

(1) (a) A pharmacy benefit manager shall pass down the entire amount of any received prescription drug manufacturer rebate to:

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

(ii) if the enrollee does not have any cost sharing described in Subsection (1)(a)(i), the

health benefit plan to reduce premiums.

(b) Subsection (1)(a) does not apply to contracts involving an accountable care organization participating in the Medicaid program.

(2) A pharmacy benefit manager shall offer pharmacy benefits management services that do not include spread pricing as an option to a health benefit plan and a self-insured benefit plan.

Section 8. Section **31A-46-312** is enacted to read:

31A-46-312. Network requirements.

A pharmacy benefit manager that is contracting with a health benefit plan may not prohibit:

(1) an enrollee in the health benefit plan from using an out-of-network pharmacy; and

(2) an out-of-network pharmacy from charging the enrollee an amount greater than what the pharmacy benefit manager reimburses for the out-of-network pharmacy's provided service.

Section 9. **Repealer.**

This bill repeals:

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

Section 10. **Effective date.**

This bill takes effect on May 1, 2024.