

Representative Norman K Thurston proposes the following substitute bill:

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 health benefit plan to ensure pharmaceutical rebates are used for certain purposes;
- ▶ enacts provisions related to pharmacy network requirements for health benefit plans;
- ▶ modifies requirements related to pharmacy audits;
- ▶ requires pharmacy benefit manager to offer certain options to self-insured benefit plans; and
- ▶ makes technical and conforming changes.

Money Appropriated in this Bill:

None



26 **Other Special Clauses:**

27 This bill provides a special effective date.

28 **Utah Code Sections Affected:**

29 AMENDS:

30 **31A-2-212**, as last amended by Laws of Utah 2020, Chapter 32

31 **31A-22-618.5**, as last amended by Laws of Utah 2017, Chapter 292

32 **31A-22-643**, as enacted by Laws of Utah 2014, Chapter 111

33 **31A-45-303**, as last amended by Laws of Utah 2019, Chapter 193

34 **31A-46-102**, as last amended by Laws of Utah 2020, Chapters 198, 275 and 372

35 **31A-46-304**, as last amended by Laws of Utah 2020, Chapter 198

36 **58-17b-622**, as last amended by Laws of Utah 2023, Chapter 329

37 ENACTS:

38 **31A-46-311**, Utah Code Annotated 1953

39 REPEALS:

40 **31A-46-101**, as last amended by Laws of Utah 2020, Chapter 198



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

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

44 **31A-2-212. Miscellaneous duties.**

45 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to
46 do business in Utah, and when the commissioner begins a proceeding against an insurer under
47 Chapter 27a, Insurer Receivership Act, the commissioner:

48 (a) shall notify by mail the producers of the person or insurer of whom the
49 commissioner has record; and

50 (b) may publish notice of the order or proceeding in any manner the commissioner
51 considers necessary to protect the rights of the public.

52 (2) (a) When required for evidence in a legal proceeding, the commissioner shall
53 furnish a certificate of authority of a licensee to transact the business of insurance in Utah on
54 any particular date.

55 (b) The court or other officer shall receive a certificate of authority described in this
56 Subsection (2) in lieu of the commissioner's testimony.

57 (3) (a) On the request of an insurer authorized to do a surety business, the
58 commissioner shall furnish a copy of the insurer's certificate of authority to a designated public
59 officer in this state who requires that certificate of authority before accepting a bond.

60 (b) The public officer described in Subsection (3)(a) shall file the certificate of
61 authority furnished under Subsection (3)(a).

62 (c) After a certified copy of a certificate of authority is furnished to a public officer, it
63 is not necessary, while the certificate of authority remains effective, to attach a copy of it to any
64 instrument of suretyship filed with that public officer.

65 (d) Whenever the commissioner revokes the certificate of authority or begins a
66 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a
67 surety business, the commissioner shall immediately give notice of that action to each public
68 officer who is sent a certified copy under this Subsection (3).

69 (4) (a) The commissioner shall immediately notify every judge and clerk of the courts
70 of record in the state when:

71 (i) an authorized insurer doing a surety business:

72 (A) files a petition for receivership; or

73 (B) is in receivership; or

74 (ii) the commissioner has reason to believe that the authorized insurer doing surety
75 business:

76 (A) is in financial difficulty; or

77 (B) has unreasonably failed to carry out any of the authorized insurer's contracts.

78 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the
79 judges and clerks to notify and require a person that files with the court a bond on which the
80 authorized insurer doing surety business is surety to immediately file a new bond with a new
81 surety.

82 (5) (a) The commissioner shall require an insurer that issues, sells, renews, or offers
83 health insurance coverage in this state to comply with PPACA and administrative rules adopted
84 by the commissioner related to regulation of health benefit plans, including:

85 (i) lifetime and annual limits;

86 (ii) prohibition of rescissions;

87 (iii) coverage of preventive health services;

- 88 (iv) coverage for a child or dependent;
- 89 (v) pre-existing condition limitations;
- 90 (vi) insurer transparency of consumer information including plan disclosures, uniform
- 91 coverage documents, and standard definitions;
- 92 (vii) premium rate reviews;
- 93 (viii) essential health benefits;
- 94 (ix) provider choice;
- 95 (x) waiting periods;
- 96 (xi) appeals processes;
- 97 (xii) rating restrictions;
- 98 (xiii) uniform applications and notice provisions;
- 99 (xiv) certification and regulation of qualified health plans; and
- 100 (xv) network adequacy standards.

- 101 (b) The commissioner shall preserve state control over:
 - 102 (i) the health insurance market in the state;
 - 103 (ii) qualified health plans offered in the state; and
 - 104 (iii) the conduct of navigators, producers, and in-person assisters operating in the state.

105 (6) If requested by an association that represents pharmacies or pharmacists, the
106 commissioner shall assist the association in developing a form that outlines a pharmacy's rights
107 under state and federal law related to pharmacy benefits, pharmacy benefit managers, and
108 health benefit plans.

109 Section 2. Section **31A-22-618.5** is amended to read:

110 **31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.**

111 (1) The purpose of this section is to increase the range of health benefit plans available
112 in the small group, small employer group, large group, and individual insurance markets.

113 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
114 Organizations and Limited Health Plans:

115 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
116 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
117 and

118 (b) may offer to a potential purchaser one or more health benefit plans that:

119 (i) are not subject to one or more of the following:
120 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
121 (B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
122 Section 31A-8-101; or
123 (C) coverage mandates enacted after January 1, 2009₂ that are not required by federal
124 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
125 enacted after January 1, 2009; and

126 (ii) when offering a health plan under this section, provide coverage for an emergency
127 medical condition as required by Section 31A-22-627.

128 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
129 Maintenance Organizations and Limited Health Plans:

130 (a) may offer a health benefit plan that is not subject to Section 31A-22-618 and
131 Subsection [~~31A-45-303(3)(b)(iii)~~] 31A-45-303(3)(b);

132 (b) when offering a health plan under this Subsection (3), shall provide coverage of
133 emergency care services as required by Section 31A-22-627; and

134 (c) is not subject to coverage mandates enacted after January 1, 2009₂ that are not
135 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
136 after January 1, 2009.

137 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
138 Subsection (2)(b).

139 (5) (a) Any difference in price between a health benefit plan offered under Subsections
140 (2)(a) and (b) shall be based on actuarially sound data.

141 (b) Any difference in price between a health benefit plan offered under Subsection
142 (3)(a) shall be based on actuarially sound data.

143 (6) Nothing in this section limits the number of health benefit plans that an insurer may
144 offer.

145 Section 3. Section 31A-22-643 is amended to read:

146 **31A-22-643. Prescription synchronization -- Copay and dispensing fee**
147 **restrictions -- Rebate pass down -- Pharmacy networks.**

148 (1) For purposes of this section:

149 (a) "Copay" means the copay normally charged for a prescription drug.

150 (b) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).

151 (c) "Network pharmacy" means a pharmacy included in a health insurance plan's
152 network of pharmacy providers.

153 (d) "Prescription drug" means a prescription drug, as defined in Section 58-17b-102,
154 that is prescribed for a chronic condition.

155 (e) "Rebate" means the same as that term is defined in Section 31A-46-102.

156 (2) A health insurance plan may not charge an amount in excess of the copay for the
157 dispensing of a prescription drug in a quantity less than the prescribed amount if:

158 (a) the pharmacy dispenses the prescription drug in accordance with the health insurer's
159 synchronization policy; and

160 (b) the prescription drug is dispensed by a network pharmacy.

161 (3) A health insurance plan that includes a prescription drug benefit:

162 (a) shall implement a synchronization policy for the dispensing of prescription drugs to
163 the plan's enrollees; and

164 (b) may not base the dispensing fee for an individual prescription on the quantity of the
165 prescription drug dispensed to fill or refill the prescription unless otherwise agreed to by the
166 plan and the contracted pharmacy at the time the individual requests synchronization.

167 (4) [~~This section applies to health benefit plans renewed or entered into on or after~~
168 ~~January 1, 2015.~~]

169 (a) A health benefit plan shall ensure that each pharmaceutical manufacturer rebate is:

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

171 (ii) if the enrollee does not have any cost sharing described in Subsection (4)(a)(i), used
172 to reduce premiums or enhance health benefits.

173 (b) When passing down a rebate as described in Subsection (4)(a), a health benefit plan
174 or the health benefit plan's pharmacy benefit manager may:

175 (i) for a rebate pass down during the coinsurance phase of a contract, divide the rebate
176 between the health benefit plan and the enrollee in a manner that is proportional to the
177 coinsurance responsibility of the health benefit plan;

178 (ii) limit the amount passed down to the amount of the enrollee's payment
179 responsibility; or

180 (iii) estimate the amount of a rebate for a given quarter and adjust the amount of a

181 rebate passed down to account for any overpayment or underpayment in the subsequent quarter
182 for the same product.

183 (5) Subsection (4) does not apply:

184 (a) if the health benefit plan and the health benefit plan's pharmacy benefit manager
185 ensure an enrollee only pays an amount equal to the true net price of a drug less any health
186 benefit plan cost sharing requirement at the time of the prescription drug claim;

187 (b) if the enrollee is using any form of copay assistance, including direct payment to
188 the enrollee or pharmacy from a pharmaceutical manufacturer; or

189 (c) to a large employer group health benefit plan if the large employer group health
190 benefit plan uses each rebate received to reduce premiums or enhance health benefits.

191 (6) A health benefit plan may not prohibit or condition participation in one pharmacy
192 network on participation in another pharmacy network.

193 (7) The Public Employees' Benefit and Insurance Program shall alter plan design to
194 ensure cost neutrality to the state and for compliance with Subsections (4), (5), and (6).

195 (8) Subsections (4), (5), and (6) apply to a health benefit plan renewed or entered into
196 on or after July 1, 2025.

197 Section 4. Section **31A-45-303** is amended to read:

198 **31A-45-303. Network provider contract provisions.**

199 (1) Managed care organizations may provide for enrollees to receive services or
200 reimbursement in accordance with this section.

201 (2) (a) Subject to restrictions under this section, a managed care organization may enter
202 into contracts with health care providers under which the health care providers agree to be a
203 network provider and supply services, at prices specified in the contracts, to enrollees.

204 (b) A network provider contract shall require the network provider to accept the
205 specified payment in this Subsection (2) as payment in full, relinquishing the right to collect
206 amounts other than copayments, coinsurance, and deductibles from the enrollee.

207 (c) The insurance contract may reward the enrollee for selection of network providers
208 by:

209 (i) reducing premium rates;

210 (ii) reducing deductibles;

211 (iii) coinsurance;

212 (iv) other copayments; or

213 (v) any other reasonable manner.

214 (3) (a) When reimbursing for services of health care providers that are not network
215 providers, the managed care organization may:

216 (i) make direct payment to the enrollee; and

217 (ii) impose a deductible on coverage of health care providers not under contract.

218 (b) ~~[(i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed~~
219 ~~under:]~~

220 ~~[(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;]~~

221 ~~[(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or]~~

222 ~~[(C) Chapter 14, Foreign Insurers; and]~~

223 ~~[(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed~~
224 ~~care organization licensed under Chapter 8, Health Maintenance Organizations and Limited~~
225 ~~Health Plans.]~~

226 ~~[(iii)]~~ When selecting health care providers with whom to contract under Subsection
227 (2), a managed care organization ~~[described in Subsection (3)(b)(i)]~~ may not unfairly
228 discriminate between classes of health care providers, but may discriminate within a class of
229 health care providers, subject to Subsection (6).

230 (c) For purposes of this section, unfair discrimination between classes of health care
231 providers includes:

232 (i) refusal to contract with class members in reasonable proportion to the number of
233 insureds covered by the insurer and the expected demand for services from class members; and

234 (ii) refusal to cover procedures for one class of providers that are:

235 (A) commonly used by members of the class of health care providers for the treatment
236 of illnesses, injuries, or conditions;

237 (B) otherwise covered by the managed care organization; and

238 (C) within the scope of practice of the class of health care providers.

239 (4) Before the enrollee consents to the insurance contract, the managed care
240 organization shall fully disclose to the enrollee that the managed care organization has entered
241 into network provider contracts. The managed care organization shall provide sufficient detail
242 on the network provider contracts to permit the enrollee to agree to the terms of the insurance

243 contract. The managed care organization shall provide at least the following information:

244 (a) a list of the health care providers under contract, and if requested their business
245 locations and specialties;

246 (b) a description of the insured benefits, including deductibles, coinsurance, or other
247 copayments;

248 (c) a description of the quality assurance program required under Subsection (5); and

249 (d) a description of the adverse benefit determination procedures required under
250 Section [31A-22-629](#).

251 (5) (a) A managed care organization using network provider contracts shall maintain a
252 quality assurance program for assuring that the care provided by the network providers meets
253 prevailing standards in the state.

254 (b) The commissioner in consultation with the executive director of the Department of
255 Health and Human Services may designate qualified persons to perform an audit of the quality
256 assurance program. The auditors shall have full access to all records of the managed care
257 organization and the managed care organization's health care providers, including medical
258 records of individual patients.

259 (c) The information contained in the medical records of individual patients shall
260 remain confidential. All information, interviews, reports, statements, memoranda, or other data
261 furnished for purposes of the audit and any findings or conclusions of the auditors are
262 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
263 proceeding except hearings before the commissioner concerning alleged violations of this
264 section.

265 (6) (a) A health care provider or managed care organization may not discriminate
266 against a network provider for agreeing to a contract under Subsection (2).

267 (b) ~~[(i) Subsections (6)(b) and (c) apply to a managed care organization that is~~
268 ~~described in Subsection (3)(b)(i) and do not apply to a managed care organization described in~~
269 ~~Subsection (3)(b)(ii).]~~

270 ~~[(ii)]~~ A health care provider licensed to treat an illness or injury within the scope of the
271 health care provider's practice, that is willing and able to meet the terms and conditions
272 established by the managed care organization for designation as a network provider, shall be
273 able to apply for and receive the designation as a network provider. Contract terms and

274 conditions may include reasonable limitations on the number of designated network providers
275 based upon substantial objective and economic grounds, or expected use of particular services
276 based upon prior provider-patient profiles.

277 (c) Upon the written request of a provider excluded from a network provider contract,
278 the commissioner may hold a hearing to determine if the managed care organization's exclusion
279 of the provider is based on the criteria set forth in Subsection (6)(b).

280 (7) Nothing in this section is to be construed as to require a managed care organization
281 to offer a certain benefit or service as part of a health benefit plan.

282 (8) Notwithstanding Subsection (2) or (6)(b), a managed care organization [~~described~~
283 ~~in Subsection (3)(b)(i)] or third party administrator is not required to, but may, enter into a
284 contract with a licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer
285 Licensing Act.~~

286 Section 5. Section **31A-46-102** is amended to read:

287 **31A-46-102. Definitions.**

288 As used in this chapter:

289 (1) "340B drug" means a drug purchased through the 340B drug discount program by a
290 340B entity.

291 (2) "340B drug discount program" means the 340B drug discount program described in
292 42 U.S.C. Sec. 256b.

293 (3) "340B entity" means:

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

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

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

298 (4) "Administrative fee" means any payment[~~, other than a rebate, that a~~
299 ~~pharmaceutical manufacturer makes directly or indirectly to a pharmacy benefit manager] that
300 is directly attributable to the pharmacy benefit manager's activities to invoice, collect, audit,
301 and account for funds received from a pharmaceutical manufacturer.~~

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

304 (6) "Contracting insurer" means an insurer with whom a pharmacy benefit manager

305 contracts to provide a pharmacy benefit management service.

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

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

309 [~~(9)~~] (8) "Direct or indirect remuneration" means any adjustment in the total
310 compensation:

311 (a) received by a pharmacy from a pharmacy benefit manager for the sale of a drug,
312 device, or other product or service; and

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

314 [~~(10)~~] (9) "Dispense" means the same as that term is defined in Section 58-17b-102.

315 [~~(11)~~] (10) "Drug" means the same as that term is defined in Section 58-17b-102.

316 [~~(12)~~] (11) "Insurer" means the same as that term is defined in Section 31A-22-636.

317 [~~(13)~~] (12) "Maximum allowable cost" means:

318 (a) a maximum reimbursement amount for a group of pharmaceutically and
319 therapeutically equivalent drugs; or

320 (b) any similar reimbursement amount that is used by a pharmacy benefit manager to
321 reimburse pharmacies for multiple source drugs.

322 [~~(14)~~] (13) "Medicaid program" means the same as that term is defined in Section
323 26B-3-101.

324 [~~(15)~~] (14) "Obsolete" means a product that may be listed in national drug pricing
325 compendia but is no longer available to be dispensed based on the expiration date of the last lot
326 manufactured.

327 [~~(16)~~] (15) "Patient counseling" means the same as that term is defined in Section
328 58-17b-102.

329 [~~(17)~~] (16) "Pharmaceutical facility" means the same as that term is defined in Section
330 58-17b-102.

331 [~~(18)~~] (17) "Pharmaceutical manufacturer" means a pharmaceutical facility that
332 manufactures prescription drugs.

333 [~~(19)~~] (18) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

334 [~~(20)~~] (19) "Pharmacy" means the same as that term is defined in Section 58-17b-102.

335 [~~(21)~~] (20) "Pharmacy benefits management service" means any of the following

336 services provided to a health benefit plan, or to a participant of a health benefit plan:

337 (a) negotiating the amount to be paid by a health benefit plan for a prescription drug; or

338 (b) administering or managing a prescription drug benefit provided by the health

339 benefit plan for the benefit of a participant of the health benefit plan, including administering

340 or managing:

341 (i) an out-of-state mail service pharmacy;

342 (ii) a specialty pharmacy;

343 (iii) claims processing;

344 (iv) payment of a claim;

345 (v) retail network management;

346 (vi) clinical formulary development;

347 (vii) clinical formulary management services;

348 (viii) rebate contracting;

349 (ix) rebate administration;

350 (x) a participant compliance program;

351 (xi) a therapeutic intervention program;

352 (xii) a disease management program; or

353 (xiii) a service that is similar to, or related to, a service described in Subsection

354 ~~[(21)(a)]~~ (20)(a) or ~~[(21)(b)(i) through (xii)]~~ this Subsection (20)(b).

355 ~~[(22)]~~ (21) "Pharmacy benefit manager" means a person licensed under this chapter to

356 provide a pharmacy benefits management service.

357 ~~[(23)]~~ (22) "Pharmacy service" means a product, good, or service provided to an

358 individual by a pharmacy or pharmacist.

359 ~~[(24)]~~ (23) "Pharmacy services administration organization" means an entity that

360 contracts with a pharmacy to assist with third-party payer interactions and administrative

361 services related to third-party payer interactions, including:

362 (a) contracting with a pharmacy benefit manager on behalf of the pharmacy; and

363 (b) managing a pharmacy's claims payments from third-party payers.

364 ~~[(25)]~~ (24) "Pharmacy service entity" means:

365 (a) a pharmacy services administration organization; or

366 (b) a pharmacy benefit manager.

367 ~~[(26)]~~ (25) "Prescription device" means the same as that term is defined in Section
368 58-17b-102.

369 ~~[(27)]~~ (26) "Prescription drug" means the same as that term is defined in Section
370 58-17b-102.

371 ~~[(28)]~~ (27) (a) "Rebate" ~~[means a refund, discount, or other price concession that is~~
372 ~~paid by a pharmaceutical manufacturer to a pharmacy benefit manager based on a prescription~~
373 ~~drug's utilization or effectiveness.]~~ means all payments that accrue directly or indirectly to a
374 pharmacy benefit manager or a health benefit plan from a pharmaceutical manufacturer.

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

376 ~~[(29)]~~ (28) (a) "Reimbursement report" means a report on the adjustment in total
377 compensation for a claim.

378 (b) "Reimbursement report" does not include a report on adjustments made pursuant to
379 a pharmacy audit or reprocessing.

380 ~~[(30)]~~ (29) "Retail pharmacy" means the same as that term is defined in Section
381 58-17b-102.

382 ~~[(31)]~~ (30) "Sale" means a prescription drug or prescription device claim covered by a
383 health benefit plan.

384 (31) "Spread pricing" means the practice in which a pharmacy benefit manager charges
385 a health benefit plan a different amount for pharmacist services than the amount the pharmacy
386 benefit manager reimburses a pharmacy for the pharmacist's services.

387 (32) "Wholesale acquisition cost" means the same as that term is defined in 42 U.S.C.
388 Sec. 1395w-3a.

389 Section 6. Section ~~31A-46-304~~ is amended to read:

390 **31A-46-304. Claims practices.**

391 (1) A pharmacy benefit manager shall permit a pharmacy to collect the amount of a
392 customer's cost share from any source.

393 (2) A pharmacy benefit manager may not deny or reduce a reimbursement to a
394 pharmacy or a pharmacist after the adjudication of the claim, unless:

395 (a) the pharmacy or pharmacist submitted the original claim fraudulently;

396 (b) the original reimbursement was incorrect because:

397 (i) the pharmacy or pharmacist had already been paid for the pharmacy service; or

398 (ii) an unintentional error resulted in an incorrect reimbursement; or

399 (c) the pharmacy service was not rendered by the pharmacy or pharmacist.

400 (3) (a) A finding of overpayment or underpayment shall be based on the actual
401 overpayment or underpayment of a specific individual claim.

402 (b) Any amount to be charged back or recouped due to overpayment may not exceed
403 the amount the pharmacy was overpaid.

404 [~~3~~] (4) Subsection (2) does not apply if:

405 (a) any form of an investigation or audit of pharmacy records for fraud, waste, abuse,
406 or other intentional misrepresentation indicates that the pharmacy or pharmacist engaged in
407 criminal wrongdoing, fraud, or other intentional misrepresentation; or

408 (b) the reimbursement is reduced as the result of the reconciliation of a reimbursement
409 amount under a performance contract if:

410 (i) the performance contract lays out clear performance standards under which the
411 reimbursement for a specific drug may be increased or decreased; and

412 (ii) the agreement between the pharmacy benefit manager and the pharmacy or
413 pharmacist explicitly states, in a separate document that is signed by the pharmacy benefit
414 manager and the pharmacy or pharmacist, that the provisions of Subsection (2) do not apply.

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

416 **31A-46-311. Options for self-insured benefit plans.**

417 A pharmacy benefit manager shall offer to a self-insured benefit plan, as an option for
418 the self-insured benefit's plan design, pharmacy benefits management services that:

419 (1) comply with the provisions of Subsections [31A-22-643](#)(4), (5), and (6), collectively
420 and individually; and

421 (2) do not include spread pricing.

422 Section 8. Section **58-17b-622** is amended to read:

423 **58-17b-622. Pharmacy benefit management services -- Auditing of pharmacy**
424 **records -- Appeals.**

425 (1) For purposes of this section:

426 (a) "Audit" means a review of the records of a pharmacy by or on behalf of an entity
427 that finances or reimburses the cost of health care services or pharmaceutical products.

428 (b) "Audit completion date" means:

429 (i) for an audit that does not require an on-site visit at the pharmacy, the date on which
430 the pharmacy, in response to the initial audit request, submits records or other documents to the
431 entity conducting the audit, as determined by:

432 (A) postmark or other evidence of the date of mailing; or

433 (B) the date of transmission if the records or other documents are transmitted
434 electronically; and

435 (ii) for an audit that requires an on-site visit at a pharmacy, the date on which the
436 auditing entity completes the on-site visit, including any follow-up visits or analysis which
437 shall be completed within 60 days after the day on which the on-site visit begins.

438 (c) "Entity" includes:

439 (i) a pharmacy benefits manager or coordinator;

440 (ii) a health benefit plan;

441 (iii) a third party administrator as defined in Section 31A-1-301;

442 (iv) a state agency; or

443 (v) a company, group, or agent that represents, or is engaged by, one of the entities
444 described in Subsections (1)(c)(i) through (iv).

445 (d) "Extrapolation" means a method of using a mathematical formula that uses the
446 audit results from a small sample of insurance claims and projects the results over a larger
447 group of insurance claims.

448 [~~(d)~~] (e) "Fraud" means an intentional act of deception, misrepresentation, or
449 concealment in order to gain something of value.

450 [~~(e)~~] (f) "Health benefit plan" means:

451 (i) a health benefit plan as defined in Section 31A-1-301; or

452 (ii) a health, dental, medical, Medicare supplement, or conversion program offered
453 under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

454 (2) (a) Except as provided in Subsection (2)(b), this section applies to:

455 (i) a contract for the audit of a pharmacy entered into, amended, or renewed on or after
456 July 1, 2012; and

457 (ii) an entity that conducts an audit of the pharmacy records of a pharmacy licensed
458 under this chapter.

459 (b) This section does not apply to an audit of pharmacy records:

460 (i) for a federally funded prescription drug program, including:

461 (A) the state Medicaid program;

462 (B) the Medicare Part D program;

463 (C) a Department of Defense prescription drug program; and

464 (D) a Veterans Affairs prescription drug program; or

465 (ii) when fraud or other intentional and willful misrepresentation is alleged and the
466 pharmacy audit entity has evidence that the pharmacy's actions reasonably indicate fraud or
467 intentional and willful misrepresentation.

468 (3) (a) An audit that involves clinical or professional judgment shall be conducted by
469 or in consultation with a pharmacist who is employed by or working with the auditing entity
470 and who is licensed in the state or another state.

471 (b) If an audit is conducted on site at a pharmacy, the entity conducting the audit:

472 (i) shall give the pharmacy 10 days advanced written notice of:

473 (A) the audit; and

474 (B) the range of prescription numbers or a date range included in the audit; and

475 (ii) may not audit a pharmacy during the first five business days of the month, unless
476 the pharmacy agrees to the timing of the audit.

477 (c) An entity may not audit claims:

478 (i) submitted more than 18 months prior to the audit, unless:

479 (A) required by federal law; or

480 (B) the originating prescription is dated in the preceding six months; or

481 (ii) that exceed 200 selected prescription claims annually.

482 (d) Subsection (3)(c)(ii) does not apply to any investigative audit that involves fraud,
483 waste, abuse, or willful misrepresentation.

484 (4) (a) An entity may not:

485 (i) include dispensing fees in the calculations of overpayments unless the prescription
486 is considered a misfill;

487 (ii) recoup funds for prescription clerical or recordkeeping errors, including
488 typographical errors, scrivener's errors, and computer errors on a required document or record
489 unless the audit entity is alleging fraud or other intentional or willful misrepresentation and the
490 audit entity has evidence that the pharmacy's actions reasonably indicate fraud or intentional

491 and willful misrepresentation;

492 (iii) recoup funds for refills dispensed in accordance with Section 58-17b-608.1, unless
493 the health benefit plan does not cover the prescription drug dispensed by the pharmacy;

494 (iv) collect any funds, charge-backs, or penalties until the audit and all appeals are
495 final, unless the audit entity is alleging fraud or other intentional or willful misrepresentation
496 and the audit entity has evidence that the pharmacy's actions reasonably indicate fraud or
497 intentional and willful misrepresentation; or

498 (v) recoup funds or collect any funds, charge-backs, or penalties from a pharmacy in
499 response to a request for audit unless the pharmacy confirms to the entity the date on which the
500 pharmacy received the request for audit.

501 (b) Auditors shall only have access to previous audit reports on a particular pharmacy
502 if the previous audit was conducted by the same entity except as required for compliance with
503 state or federal law.

504 (5) A pharmacy subject to an audit:

505 (a) may use one or more of the following to validate a claim for a prescription, refill, or
506 change in a prescription:

507 (i) electronic or physical copies of records of a health care facility, or a health care
508 provider with prescribing authority;

509 (ii) any prescription that complies with state law;

510 (iii) the pharmacy's own physical or electronic records; or

511 (iv) the physical or electronic records, or valid copies of the physical or electronic
512 records, of a practitioner or health care facility as defined in Section 26B-2-201; and

513 (b) may not be required to provide the following records to validate a claim for a
514 prescription, refill, or change in a prescription:

515 (i) if the prescription was handwritten, the physical handwritten version of the
516 prescription; or

517 (ii) a note from the practitioner regarding the patient or the prescription that is not
518 otherwise required for a prescription under state or federal law.

519 (6) (a) (i) An entity that audits a pharmacy shall establish:

520 (A) a maximum time for the pharmacy to submit records or other documents to the
521 entity following receipt of an audit request for records or documents; and

522 (B) a maximum time for the entity to provide the pharmacy with a preliminary audit
523 report following submission of records under Subsection (6)(a)(i)(A).

524 (ii) The time limits established under Subsections (6)(a)(i)(A) and (B):

525 (A) shall be identical; and

526 (B) may not be less than seven days or more than 60 days.

527 (iii) An entity that audits a pharmacy may not, after the audit completion date, request
528 additional records or other documents from the pharmacy to complete the preliminary audit
529 report described in Subsection (6)(b).

530 (b) An entity that audits a pharmacy shall provide the pharmacy with a preliminary
531 audit report[;]:

532 (i) delivered to the pharmacy or its corporate office of record, within the time limit
533 established under Subsection (6)(a)(i)(B)[;]; and

534 (ii) that includes a notation for each suspected error.

535 (c) (i) Except as provided in Subsection (6)(c)(ii), a pharmacy has 30 days following
536 receipt of the preliminary audit report to respond to questions, provide additional
537 documentation, and comment on and clarify findings of the audit.

538 (ii) An entity may grant a reasonable extension under Subsection (6)(c)(i) upon request
539 by the pharmacy.

540 (iii) Receipt of the report under Subsection (6)(c)(i) shall be determined by:

541 (A) postmark or other evidence of the date of mailing; or

542 (B) the date of transmission if the report is transmitted electronically.

543 (iv) If a dispute exists between the records of the auditing entity and the pharmacy, the
544 records maintained by the pharmacy shall be presumed valid for the purpose of the audit.

545 (7) If an audit results in the dispute or denial of a claim, the entity conducting the audit
546 shall allow any of the following:

547 (a) the pharmacy to resubmit a claim using any commercially reasonable method,
548 including fax, mail, or electronic claims submission provided that the period of time when a
549 claim may be resubmitted has not expired under the rules of the plan sponsor[;] and within 30
550 days from the day on which the audit report is received by the pharmacy; or

551 (b) the health benefit plan or other entity that finances or reimburses the cost of health
552 care services or pharmaceutical products to rerun the claim if the health benefit plan or other

553 entity chooses to rerun the claim at no cost to the pharmacy.

554 (8) (a) Within 60 days after the completion of the appeals process under Subsection
555 (9), a final audit report shall be delivered to the pharmacy or its corporate office of record.

556 (b) The final audit report shall include:

557 (i) a disclosure of any money recovered by the entity that conducted the audit[-]; and

558 (ii) legal or contractual information supporting any money recovered, recoupments, or
559 penalties included in the report.

560 (9) (a) An entity that audits a pharmacy shall establish a written appeals process for
561 appealing a preliminary audit report and a final audit report, and shall provide the pharmacy
562 with notice of the written appeals process.

563 (b) If the pharmacy benefit manager's contract or provider manual contains the
564 information required by this Subsection (9), the requirement for notice is met.

565 (10) An auditing entity conducting a pharmacy audit may not:

566 (a) use extrapolation when conducting an audit, including calculating recoupments or
567 penalties for audits, unless otherwise required by federal law or a self-funded insurance plan; or

568 (b) compensate an employee or contractor participating in the audit in a manner that is
569 based on the amount claimed or the actual amount recouped from the pharmacy being audited.

570 Section 9. **Repealer.**

571 This bill repeals:

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

573 Section 10. **Effective date.**

574 This bill takes effect on January 1, 2025.