CHAPTER 510B

REGULATION OF PHARMACY BENEFITS MANAGERS

Referred to in §87.4, 296.7, 331.301, 364.4, 505.28, 505.29, 507B.4, 669.14, 670.7

510B.1 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Clean claim"* means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstances requiring special treatment, that prevents timely payment from being made on the claim.

2. *"Commissioner"* means the commissioner of insurance.

3. *"Cost-sharing"* means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket cost obligation imposed by a health benefit plan on a covered person.

4. *"Covered person"* means a policyholder, subscriber, or other person participating in a health benefit plan that has a prescription drug benefit managed by a pharmacy benefits manager.

5. *"Facility"* means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

6. *"Health benefit plan"* means a policy, contract, certificate, or agreement offered or issued by a third-party payor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

7. *"Health care professional"* means a physician or other health care practitioner licensed, accredited, registered, or certified to perform specified health care services consistent with state law.

8. *"Health care provider"* means a health care professional or a facility.

9. *"Health carrier"* means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or a plan established pursuant to chapter 509A for public employees. *"Health carrier"* does not include any of the following:

a. The department of health and human services.

b. A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

c. A policy or contract providing a prescription drug benefit pursuant to 42 U.S.C. ch. 7, subch. XVIII, part D.

d. A plan offered or maintained by a multiple employer welfare arrangement established under chapter 513D before January 1, 2022.

10. *"Maximum allowable cost"* means the maximum amount that a pharmacy will be reimbursed by a pharmacy benefits manager or a health carrier for a generic drug,

brand-name drug, biologic product, or other prescription drug, and that may include any of the following:

a. Average acquisition cost.

b. National average drug acquisition cost.

c. Average manufacturer price.

d. Average wholesale price.

e. Brand effective rate.

f. Generic effective rate.

g. Discount indexing.

h. Federal upper limits.

i. Wholesale acquisition cost.

j. Any other term used by a pharmacy benefits manager or a health carrier to establish reimbursement rates for a pharmacy.

11. *"Maximum allowable cost list"* means a list of prescription drugs that includes the maximum allowable cost for each prescription drug and that is used, directly or indirectly, by a pharmacy benefits manager.

12. *"National average drug acquisition cost"* means the monthly survey of retail pharmacies conducted by the federal centers for Medicare and Medicaid services to determine average acquisition cost for Medicaid covered outpatient drugs.

13. *"Pass-through pricing"* means a model of prescription drug pricing in which payments made by a third-party payor to a pharmacy benefits manager for prescription drugs are equivalent to the payments the pharmacy benefits manager makes to the dispensing pharmacy or dispensing health care provider for the prescription drugs, including any professional dispensing fee.

14. *"Pharmacist"* means the same as defined in section 155A.3.

15. *"Pharmacy"* means the same as defined in section 155A.3.

16. *"Pharmacy acquisition cost"* means the cost to a pharmacy for a prescription drug as invoiced by a wholesale distributor, and reduced by any discounts, rebates, or other price concessions applicable to the prescription drug that are not shown on the invoice and are known at the time that the pharmacy files an appeal with a pharmacy benefits manager.

17. *"Pharmacy benefits manager"* means a person who, pursuant to a contract or other relationship with a third-party payor, either directly or through an intermediary, manages a prescription drug benefit provided by the third-party payor.

18. *"Pharmacy benefits manager affiliate"* means a pharmacy or a pharmacist that directly or indirectly through one or more intermediaries, owns or controls, is owned and controlled by, or is under common ownership or control of, a pharmacy benefits manager.

19. *"Pharmacy chain"* means an entity that has twenty or more pharmacies under common ownership or control located in at least twenty or more states.

20. *"Pharmacy network"* or *"network"* means pharmacies that have contracted with a pharmacy benefits manager to dispense or sell prescription drugs to covered persons of a health benefit plan for which the pharmacy benefits manager manages the prescription drug benefit.

21. *"Prescription drug"* means the same as defined in section 155A.3.

22. *"Prescription drug benefit"* means a health benefit plan providing for third-party payment or prepayment for prescription drugs.

23. *"Prescription drug order"* means the same as defined in section 155A.3.

24. *"Rebate"* means all discounts and other negotiated price concessions paid directly or indirectly by a pharmaceutical manufacturer or other entity, other than a covered person, in the prescription drug supply chain to a pharmacy benefits manager, and which may be based on any of the following:

a. A pharmaceutical manufacturer's list price for a prescription drug.

b. Utilization.

c. To maintain a net price for a prescription drug for a specified period of time for the pharmacy benefits manager in the event the pharmaceutical manufacturer's list price increases.

d. Reasonable estimates of the volume of a prescribed drug that will be dispensed by a pharmacy to covered persons.

25. *"Retail pharmacy"* means a pharmacy that is not a pharmacy chain or a publicly traded entity, and that does not exclusively provide mail order dispensing of prescription drugs.

26. *"Specialty drug"* means a drug used to treat chronic and complex, or rare medical conditions and that requires special handling or administration, provider care coordination, or patient education that cannot be provided by a nonspecialty pharmacy or pharmacist.

27. *"Third-party payor"* means any entity other than a covered person or a health care provider that is responsible for any amount of reimbursement for a prescription drug benefit. *"Third-party payor"* includes health carriers and other entities that provide a plan of health insurance or health care benefits. *"Third-party payor"* does not include any of the following:

a. The department of health and human services.

b. A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

c. A policy or contract providing a prescription drug benefit pursuant to 42 U.S.C. ch. 7, subch. XVIII, part D.

28. *"Wholesale acquisition cost"* means the same as defined in 42 U.S.C. §1395w-3a(c)(6)(B).

29. *"Wholesale distributor"* means the same as defined in section 155A.3.

2007 Acts, ch 193, §1, 9; 2014 Acts, ch 1016, §1; 2022 Acts, ch 1113, §2, 16, 23; 2023 Acts, ch 19, §1188; 2024 Acts, ch 1100, §1; 2025 Acts, ch 151, §1, 9

Referred to in §505.26, 510C.1, 510D.1

Subsections 12, 13, 19, 25, 26, and 28 apply to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

NEW subsections 12, 13, 19, 25, 26, and 28 and section editorially internally renumbered

510B.2 Certification as a third-party administrator required.

A pharmacy benefits manager doing business in this state shall obtain a certificate as a third-party administrator under chapter 510, and the provisions relating to a third-party administrator pursuant to chapter 510 shall apply to a pharmacy benefits manager.

2007 Acts, ch 193, §2, 9

510B.3 Enforcement — rules. Repealed by 2022 Acts, ch 1113, §15, 16, 23. See §510B.10 and 510B.11.

510B.4 Standards of conduct — good faith — conflict of interest.

1. A pharmacy benefits manager shall exercise good faith and fair dealing in the performance of the pharmacy benefits manager's contractual obligations toward a third-party payor or a pharmacy.

2. A pharmacy benefits manager shall notify a health carrier in writing of any activity, policy, practice ownership interest, or affiliation of the pharmacy benefits manager that presents any conflict of interest.

3. A pharmacy benefits manager shall act in the best interest of each third-party payor for whom the pharmacy benefits manager manages a prescription drug benefit provided by the third-party payor, and shall discharge its duties in accordance with applicable state and federal law.

4. A pharmacy benefits manager, health carrier, health benefit plan, or third-party payor shall not discriminate against a pharmacy or a pharmacist with respect to participation, referral, reimbursement of a covered service, or indemnification if a pharmacist is acting within the scope of the pharmacist's license, as permitted under state law, and the pharmacy is operating in compliance with all applicable laws and rules.

2007 Acts, ch 193, §4, 9; 2022 Acts, ch 1113, §3, 16, 23; 2024 Acts, ch 1100, §2; 2025 Acts, ch 151, §2, 9

Subsection 4 applies to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

NEW subsection 4

510B.4A Retaliation prohibited.

A pharmacy benefits manager shall not retaliate against a pharmacy based on the pharmacy's exercise of any right or remedy under this chapter, including but not limited to filing a complaint with the commissioner or cooperating with the commissioner pursuant to the commissioner's authority under this chapter. Retaliation prohibited by this section shall include but is not limited to all of the following:

1. Terminating or refusing to renew a contract with the pharmacy.
2. Subjecting the pharmacy to increased audits.
3. Withholding or failing to promptly pay the pharmacy any money owed by the pharmacy benefits manager to the pharmacy.

2024 Acts, ch 1100, §3

510B.4B Prohibited conduct — pharmacy rights.

1. A pharmacy benefits manager shall not do any of the following:

a. If a pharmacy or pharmacist has agreed to participate in a covered person's health benefit plan, prohibit or limit the covered person from selecting a pharmacy or pharmacist of the covered person's choice, or impose a monetary advantage or penalty that would affect a covered person's choice. A monetary advantage or penalty includes a copayment or coinsurance variation, a reduction in reimbursement for services, a promotion of one participating pharmacy over another, or comparing the reimbursement rates of a pharmacy against mail order pharmacy reimbursement rates.

b. Deny a pharmacy or pharmacist the right to participate as a contract provider under a health benefit plan if the pharmacy or pharmacist agrees to provide pharmacy services that meet the terms and requirements of the health benefit plan and the pharmacy or pharmacist agrees to the terms of reimbursement set forth by the third-party payor for similarly classified pharmacies.

c. Impose upon a pharmacy or pharmacist, as a condition of participation in a third-party payor network, any course of study, accreditation, certification, or credentialing that is inconsistent with, more stringent than, or in addition to state requirements for licensure or certification, and the administrative rules adopted by the board of pharmacy.

d. Unreasonably designate a prescription drug as a specialty drug to prevent a covered person from accessing the prescription drug, or limiting a covered person's access to the prescription drug, from a pharmacy or pharmacist that is within the health carrier's network. A covered person or pharmacy harmed by an alleged violation of this paragraph may file a complaint with the commissioner, and the commissioner shall, in consultation with the board of pharmacy, make a determination as to whether the covered prescription drug meets the definition of a specialty drug.

e. Require a covered person, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail order pharmacy.

f. Impose upon a covered person a copayment, reimbursement amount, number of days of a prescription drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from a pharmacy that is more costly or restrictive than would be imposed upon the covered person if such pharmacy services were purchased from a mail order pharmacy, or any other pharmacy that can provide the same pharmacy services for the same cost and copayment as a mail order service.

2. *a.* If a third-party payor providing reimbursement to covered persons for prescription drugs restricts pharmacy participation, the third-party payor shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan restriction, and offer the pharmacies the opportunity to participate in the health benefit plan at least sixty days prior to the effective date of the health benefit plan restriction. All pharmacies in the geographical coverage area of the health benefit plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services and prescription drugs.

b. The third-party payor shall inform covered persons of the names and locations of all pharmacies participating in the health benefit plan as providers of pharmacy services and prescription drugs.

c. A participating pharmacy shall be entitled to announce to the pharmacy's customers that the pharmacy participates in the health benefit plan.

3. The commissioner shall not certify a pharmacy benefits manager or license an insurance producer that is not in compliance with this section.

4. A covered person or pharmacy injured by a violation of this section may maintain a cause of action to enjoin the continuation of the violation.

2025 Acts, ch 151, §3, 9

Section applies to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

NEW section

510B.5 Contacting covered persons — requirements.

A pharmacy benefits manager, unless authorized pursuant to the terms of its contract with a health carrier, shall not contact any covered person without the express written permission of the health carrier.

2007 Acts, ch 193, §5, 9; 2022 Acts, ch 1113, §4, 16, 23

510B.6 Substitute prescription drugs.

1. The following provisions shall apply if a pharmacy benefits manager requests the dispensing of a substitute prescription drug for a drug prescribed for a covered person:

a. The pharmacy benefits manager may request the substitution of a lower priced generic and therapeutically equivalent prescription drug for a higher priced prescription drug.

b. If the substitute prescription drug's net cost to the covered person or to the health carrier exceeds the cost of the prescription drug originally prescribed for the covered person, the substitution shall be made only for medical reasons that benefit the covered person.

2. A pharmacy benefits manager shall obtain the approval of the prescribing health care professional prior to requesting any substitution under this section.

3. A pharmacy benefits manager shall not substitute an equivalent prescription drug contrary to a prescription drug order that prohibits a substitution.

2007 Acts, ch 193, §6, 9; 2022 Acts, ch 1113, §5, 16, 23

510B.7 Pharmacy fees.

A pharmacy benefits manager shall not assess, charge, or collect any form of remuneration that passes from a pharmacy or a pharmacist to the pharmacy benefits manager including but not limited to claim processing fees, performance-based fees, network participation fees, or accreditation fees.

2007 Acts, ch 193, §7, 9; 2022 Acts, ch 1113, §6, 16, 23; 2024 Acts, ch 1100, §4

510B.8 Prescription drugs — point of sale.

1. A covered person shall not be required to make a cost-sharing payment at the point of sale for a prescription drug in an amount that exceeds the total amount that the pharmacy at which the covered person fills the covered person's prescription drug order is reimbursed.

2. A pharmacy benefits manager shall not prohibit a pharmacy from disclosing the availability of a lower-cost prescription drug option to a covered person, or from selling a lower-cost prescription drug option to a covered person.

3. A pharmacy benefits manager shall not impose different cost-sharing or additional fees on a covered person based on the pharmacy at which the covered person fills a prescription drug order.

4. For the purpose of reducing premiums, one hundred percent of all rebates received by a pharmacy benefits manager shall be passed through to the health carrier, or to the employee plan sponsor as permitted by the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq.

5. A pharmacy benefits manager shall include any amount paid by a covered person, or on behalf of a covered person, when calculating the covered person's total contribution toward the covered person's cost-sharing.

6. Any amount paid by a covered person for a prescription drug shall be applied to any

deductible imposed on the covered person by the covered person's health benefit plan in accordance with the health benefit plan's coverage documents.

7. If a covered person's policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses qualifies as a high-deductible health plan under section 223 of the Internal Revenue Code, and a copayment, coinsurance, or deductible paid by the covered person as a cost-sharing requirement under this chapter would result in the covered person becoming ineligible for a health savings account associated with the covered person's high-deductible health plan, subsection 5 shall apply only after the covered person satisfies the covered person's minimum deductible, except for items or services determined to be preventive care under section 223(c)(2)(C) of the Internal Revenue Code.

2014 Acts, ch 1016, §2; 2022 Acts, ch 1113, §7, 16, 23; 2025 Acts, ch 151, §4, 9

Subsections 3 – 7 apply to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

NEW subsections 3 – 7

510B.8A Maximum allowable cost lists.

1. Prior to placement of a particular prescription drug on a maximum allowable cost list, a pharmacy benefits manager shall ensure that all of the following requirements are met:

a. The particular prescription drug must be listed as therapeutically and pharmaceutically equivalent in the most recent edition of the publication entitled "Approved Drug Products with Therapeutic Equivalence Evaluations", published by the United States food and drug administration, otherwise known as the orange book.

b. The particular prescription drug must not be obsolete or temporarily unavailable.

c. The particular prescription drug must be available for purchase, without limitations, by all pharmacies in the state from a national or regional wholesale distributor that is licensed in the state.

2. For each maximum allowable cost list that a pharmacy benefits manager uses in the state, the pharmacy benefits manager shall do all of the following:

a. Provide each pharmacy in a pharmacy network reasonable access to the maximum allowable cost list to which the pharmacy is subject.

b. Update the maximum allowable cost list within seven calendar days from the date of an increase of ten percent or more in the national average drug acquisition cost of a prescription drug on the list.

c. Update the maximum allowable cost list within seven calendar days from the date of a change in the methodology, or a change in the value of a variable applied in the methodology, on which the maximum allowable cost list is based.

d. Provide a reasonable process for each pharmacy in a pharmacy network to receive prompt notice of all changes to the maximum allowable cost list to which the pharmacy is subject.

2022 Acts, ch 1113, §8, 16, 23; 2024 Acts, ch 1100, §5

510B.8B Pharmacy benefits managers — reimbursements.

1. A pharmacy benefits manager shall not reimburse any pharmacy located in the state in an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for dispensing the same prescription drug as dispensed by the pharmacy.

2. A pharmacy benefits manager shall not reimburse any retail pharmacy located in the state in an amount less than the most recently published national average drug acquisition cost for a prescription drug on the date that the prescription drug is administered or dispensed. If the most recently published national average drug acquisition cost for the prescription drug is unavailable on the date that the prescription drug is administered or dispensed, a pharmacy benefits manager shall not reimburse any retail pharmacy located in the state in an amount less than the wholesale acquisition cost for the prescription drug on the date that the prescription drug is administered or dispensed.

3. In addition to the reimbursement required under subsection 2, a pharmacy benefits manager shall reimburse the retail pharmacy or pharmacist a professional dispensing fee in the amount of ten dollars and sixty-eight cents.

4. *a.* A pharmacy benefits manager shall submit a quarterly report to the commissioner of all drugs reimbursed at ten percent or more below the national average drug acquisition cost, and all drugs reimbursed at ten percent or more above the national average drug acquisition cost, for each prescription drug appearing on the national average drug acquisition cost list on the day the prescription drug was dispensed.

b. For each prescription drug included in the report, a pharmacy benefits manager shall include all of the following information:

(1) The month the prescription drug was dispensed.

(2) The quantity of the prescription drug dispensed.

(3) The amount the pharmacy was reimbursed.

(4) If the dispensing pharmacy was an affiliate of the pharmacy benefits manager.

(5) If the prescription drug was dispensed pursuant to a government health plan.

(6) The average national drug acquisition cost for the month the prescription drug was dispensed.

c. The report shall exclude drugs dispensed pursuant to 42 U.S.C. §256b.

d. A copy of the report shall be published on the pharmacy benefits manager's public internet site for twenty-four months after the date the report is submitted to the commission.

5. This section shall not apply to a pharmacy that operates in a state-owned facility.

2022 Acts, ch 1113, §9, 16, 23; 2025 Acts, ch 151, §5, 9

2025 amendment applies to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

Section amended

510B.8C Clean claims.

After the date of receipt of a clean claim submitted by a pharmacy in a pharmacy network, a pharmacy benefits manager shall not retroactively reduce payment on the claim, either directly or indirectly except in the following circumstances:

1. The claim is found not to be a clean claim during the course of a routine audit.

2. The claim submission was fraudulent.

3. The claim submission was a duplicate submission of a claim for which the pharmacy had already received payment.

2022 Acts, ch 1113, §10, 16, 23

510B.8D Pharmacy benefits manager contracts.

1. All contracts executed, amended, adjusted, or renewed on or after July 1, 2025, that apply to prescription drug benefits on or after January 1, 2026, between a pharmacy benefits manager and a third-party payor, or between a person and a third-party payor, shall include all of the following requirements:

a. The pharmacy benefits manager shall use pass-through pricing.

b. Payments received by a pharmacy benefits manager for services provided by the pharmacy benefits manager to a third-party payor or to a pharmacy shall be used or distributed pursuant to the pharmacy benefits manager's contract with the third-party payor or with the pharmacy, or as otherwise required by law.

2. Unless otherwise prohibited by law, subsection 1 shall supersede any contractual terms to the contrary in any contract executed, amended, adjusted, or renewed on or after July 1, 2025, that applies to prescription drug benefits on or after January 1, 2026, between a pharmacy benefits manager and a third-party payor, or between a person and a third-party payor.

2025 Acts, ch 151, §6, 9

Section applies to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

NEW section

510B.8E Appeals and disputes.

1. A pharmacy benefits manager shall provide a reasonable process to allow a pharmacy to appeal any matter.

2. The appeals process must include all of the following:

a. A dedicated telephone number at which a pharmacy may contact the pharmacy benefits manager and speak directly with an individual who is involved with the appeals process.

b. A dedicated electronic mail address or internet site for the purpose of submitting an appeal directly to the pharmacy benefits manager.

c. A period of no less than thirty business days after the date of a pharmacy's initial submission of a clean claim during which the pharmacy may initiate an appeal.

3. The pharmacy benefits manager shall respond to an appeal within seven business days after the date on which the pharmacy benefits manager receives the appeal.

a. If the pharmacy benefits manager grants a pharmacy's appeal related to a reimbursement rate, the pharmacy benefits manager shall do all of the following:

(1) Adjust the reimbursement rate of the prescription drug that is the subject of the appeal and provide the national drug code number that the adjustment is based on to the appealing pharmacy.

(2) Reverse and resubmit the claim that is the subject of the appeal.

(3) Make the adjustment pursuant to subparagraph (1) applicable to all of the following:

(a) Each pharmacy that is under common ownership with the pharmacy that submitted the appeal.

(b) Each pharmacy in the state that demonstrates the inability to purchase the prescription drug for less than the established reimbursement rate.

b. If the pharmacy benefits manager denies a pharmacy's appeal, the pharmacy benefits manager shall do all of the following:

(1) Provide the appealing pharmacy the national drug code number and the name of a wholesale distributor licensed pursuant to section 155A.17 from which the pharmacy can obtain the prescription drug at or below the reimbursement rate.

(2) If the prescription drug identified by the national drug code number provided by the pharmacy benefits manager pursuant to subparagraph (1) is not available below the pharmacy acquisition cost from the wholesale distributor from whom the pharmacy purchases the majority of its prescription drugs for resale, the pharmacy benefits manager shall adjust the reimbursement rate above the appealing pharmacy's pharmacy acquisition cost, and reverse and resubmit each claim affected by the pharmacy's inability to procure the prescription drug at a cost that is equal to or less than the previously appealed reimbursement rate.

2025 Acts, ch 151, §7, 9; 2025 Acts, ch 159, §15

Section applies to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025; 2025 Acts, ch 151, §9

NEW section

510B.9 Prior authorization.

A pharmacy benefits manager shall comply with all applicable prior authorization requirements pursuant to section 505.26.

2014 Acts, ch 1140, §100, 101; 2022 Acts, ch 1113, §11, 16, 23

510B.10 Enforcement.

1. The commissioner may take any enforcement action under the commissioner's authority to enforce compliance with this chapter.

2. After notice and hearing, the commissioner may issue any order or impose any penalty pursuant to section 507B.7, and may suspend or revoke a pharmacy benefits manager's certificate of registration as a third-party administrator upon a finding that the pharmacy benefits manager violated this chapter, or any applicable requirements pertaining to third-party administrators under chapter 510.

3. A pharmacy benefits manager shall be subject to the commissioner's authority to conduct an examination pursuant to chapter 507.

4. A pharmacy benefits manager is subject to the commissioner's authority to conduct a proceeding pursuant to chapter 507B. The procedures set forth in chapter 507B regarding proceedings shall apply to a proceeding related to a pharmacy benefits manager under this chapter.

5. A pharmacy benefits manager is subject to the commissioner's authority to conduct

an examination, audit, or inspection pursuant to chapter 510 for third-party administrators. The procedures set forth in chapter 510 for third-party administrators shall apply to an examination, audit, or inspection of a pharmacy benefits manager under this chapter.

6. If the commissioner conducts an examination of a pharmacy benefits manager under chapter 507; a proceeding under chapter 507B; or an examination, audit, or inspection under chapter 510, all information received from the pharmacy benefits manager, and all notes, work papers, or other documents related to the examination, proceeding, audit, or inspection shall be confidential records pursuant to chapter 22 and shall be accorded the same confidentiality as notes, work papers, investigatory materials, or other documents related to the examination of an insurer as provided in section 507.14.

7. A violation of this chapter shall be an unfair or deceptive act or practice in the business of insurance pursuant to section 507B.4, subsection 3.

2022 Acts, ch 1113, §12, 16, 23
Former section 510B.10 stricken by 2022 Acts, ch 1113, §12; see §510B.8(2)

510B.11 Rules.

The commissioner may adopt rules pursuant to chapter 17A to administer this chapter.

2022 Acts, ch 1113, §13, 16, 23

510B.12 Severability.

If a provision of this chapter or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

2022 Acts, ch 1113, §14, 16, 23