Senate File 383 - Introduced

SENATE FILE 383
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO SSB 1074)

A BILL FOR

An Act relating to pharmacy benefits managers, pharmacies, and prescription drugs and including applicability provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 510B.1, Code 2025, is amended by adding the following new subsections:

NEW SUBSECTION. 11A. *"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.

NEW SUBSECTION. 11B. *"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.

NEW SUBSECTION. 21A. *"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.

NEW SUBSECTION. 21B. *"Spread pricing"* means a pharmacy benefits manager charges a third-party payor more for prescription drugs dispensed to a covered person than the amount the pharmacy benefits manager reimburses the pharmacy for dispensing the prescription drugs to a covered person.

NEW SUBSECTION. 22A. *"Wholesale acquisition cost"* means the same as defined in 42 U.S.C. §1395w-3a(c)(6)(B).

Sec. 2. Section 510B.4, Code 2025, is amended by adding the following new subsection:

NEW SUBSECTION. 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.

Sec. 3. NEW SECTION. **510B.4B Prohibited conduct —— pharmacy rights.**

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

a. Where 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 higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another.

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.

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 the pharmacy's participation in the health benefit plan to the pharmacy's customers.

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.

5. This section shall not apply to an entity that owns and operates the entity's own facility, employs or contracts with physicians, pharmacists, nurses, or other health care personnel, and that dispenses prescription drugs from the entity's pharmacy to the entity's employees and dependents enrolled in the entity's health benefit plan, except that this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services to the entity's employees and dependents enrolled in the entity's health benefit plan.

Sec. 4. Section 510B.8, Code 2025, is amended by adding the following new subsections:

NEW SUBSECTION. 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.

NEW SUBSECTION. 4. *a.* A covered person's cost-sharing for a prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least one hundred percent of all rebates that have been received, or that will be received, by the health carrier or a pharmacy benefits manager in connection with the dispensing or administration of the prescription drug. Any additional rebate in excess of the required cost sharing shall be passed on to the health benefit plan for the purpose of reducing premiums.

b. A health carrier shall not be precluded from decreasing a covered person's cost-sharing by an amount greater than the covered person's cost-sharing as calculated under paragraph "*a*".

NEW SUBSECTION. 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.

NEW SUBSECTION. 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.

Sec. 5. Section 510B.8B, Code 2025, is amended to read as follows:

510B.8B Pharmacy benefits ~~manager affiliates~~ managers —— ~~reimbursement~~ 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. ~~The reimbursement amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.~~

2. A pharmacy benefits manager shall not reimburse any 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 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 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 ten percent or less below the national average drug acquisition cost, and all drugs reimbursed ten percent or greater than 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 a period of twenty-four months.

Sec. 6. NEW SECTION. **510B.8D Pharmacy benefits manager contracts —— spread pricing.**

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 unless paragraph "*b*" applies.

b. The pharmacy benefits manager may use direct or indirect spread pricing only if the difference between the amount the third-party payor pays the pharmacy benefits manager for a prescription drug and the amount the pharmacy benefits manager reimburses the dispensing pharmacy or dispensing health care provider for the prescription drug is passed through by the pharmacy benefits manager to the person contracted to receive third-party payor services.

c. 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.

Sec. 7. NEW SECTION. **510B.8E Appeals and disputes.**

1. A pharmacy benefits manager shall provide a reasonable process to allow a pharmacy to appeal a reimbursement rate for a specific prescription drug if the pharmacy benefits manager violates either section 510B.8A or section 510B.8B.

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 manger 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, 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 may submit the denial of the appeal to the commissioner for examination.

Sec. 8. APPLICABILITY. This Act applies to pharmacy benefits managers that manage a prescription drug benefit in the state on or after July 1, 2025.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to pharmacy benefits managers (PBMs), pharmacies, and prescription drugs.

The bill prohibits a PBM from discriminating against a pharmacy or a pharmacist (pharmacy) with regard to participation, referral, reimbursement of a covered service, or indemnification if a pharmacist acts within the scope of the pharmacist's license, as permitted under state law, and the pharmacy is operating in accordance with all applicable laws and rules.

Under the bill, where a pharmacy has agreed to participate in a covered person's (person's) health benefit plan (plan), a PBM shall not prohibit or limit the person from selecting a pharmacy of their choice, or impose a monetary advantage or penalty as described in the bill. A PBM shall not deny a pharmacy the right to participate as a contract provider under a plan if the pharmacy agrees to the terms and requirements of the plan and the terms of reimbursement. A PBM shall not impose upon

a pharmacy, as a condition of participation in a network, any course of study, accreditation, certification, or credentialing different than those imposed by state requirements and the rules adopted by the board of pharmacy. A PBM shall not unreasonably designate a prescription drug (prescription) as a specialty drug to prevent a person from accessing the prescription, or to limit a person's access to the prescription from a pharmacy that is within the person's plan's network. A person or pharmacy harmed by such a violation may file a complaint with the commissioner of insurance (commissioner). A PBM shall not require a person, as a condition of payment or reimbursement, to purchase pharmacy services exclusively through a mail order pharmacy. A PBM shall not impose upon a person any payment or condition for purchasing pharmacy services that is more costly or restrictive than if such services were purchased from a mail order pharmacy, or any other pharmacy.

If a third-party payor (payor) providing reimbursement to persons for prescriptions restricts pharmacy participation, the payor shall notify, in writing, all pharmacies within the geographical coverage area of the plan, and offer the pharmacies the opportunity to participate in the plan at least 60 days prior to the effective date of the restriction. All pharmacies in the geographical coverage area are eligible to participate under identical reimbursement terms. The payor shall inform persons of the names and locations of all pharmacies participating in the plan. A participating pharmacy shall be entitled to announce the pharmacy's participation to the pharmacy's customers. The commissioner shall not certify any PBM or license an insurance producer not in compliance with the bill.

A PBM shall not impose different cost-sharing or additional fees on a person based on the pharmacy at which the person fills a prescription order. A person's cost-sharing for a prescription shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100 percent of all rebates that have been received, or will be received, by the

health carrier or a PBM in connection with the dispensing or administration of the prescription. Any additional rebate in excess of the required cost-sharing shall be passed on to the plan for the purpose of reducing premiums. A PBM shall include any amount paid by a person, or on behalf of a person, when calculating the person's total contribution toward the person's cost-sharing. Any amount paid by a person for a prescription shall be applied to any deductible imposed on the person by the person's plan in accordance with the coverage documents.

The bill prohibits a PBM from reimbursing a pharmacy in an amount less than the national average drug acquisition cost or, if unavailable, the wholesale acquisition cost, for a prescription on the date that the prescription is administered or dispensed. A PBM also must reimburse the pharmacy a professional dispensing fee in the amount of $10.60. A PBM shall submit a quarterly report to the commissioner that contains the information detailed in the bill, and publish such report on the PBM's public internet site as described in the bill.

The bill requires all contracts executed, amended, adjusted, or renewed on or after July 1, 2025, that are applicable to prescription benefits on or after January 1, 2026, between a PBM and a payor, or between a person and a payor, to use a pass-through pricing model with an exception as detailed in the bill, and to ensure that payments received by a PBM for providing services to a payor or a pharmacy are used or distributed pursuant to the PBM's contract with the payor or with the pharmacy, or as otherwise required by law. "Pass-through pricing" and "spread pricing" are defined in the bill.

The bill requires a PBM to provide a process for pharmacies to appeal a reimbursement rate for a specific prescription. The appeal process is detailed in the bill. If a PBM denies a pharmacy's appeal, the pharmacy may submit the denial to the commissioner for examination.

The bill applies to pharmacy benefits managers that manage a prescription drug benefit in the state on or after July 1, 2025.