**Senate File 383 - Reprinted**

SENATE FILE 383
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO SSB 1074)

(As Amended and Passed by the Senate April 28, 2025)

## A BILL FOR

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

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

DIVISION I

PHARMACY BENEFITS MANAGERS

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. 16A. *"Pharmacy chain"* means an entity that has twenty or more pharmacies under common ownership or control located in at least twenty or more states.

NEW SUBSECTION. 21A. *"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.

NEW SUBSECTION. 21B. *"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. 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.* 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.

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. 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.

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.

NEW SUBSECTION. 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.

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 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.

Sec. 6. NEW SECTION. **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.

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 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 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 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.

Sec. 8. SEVERABILITY. The provisions of this division of this Act are severable pursuant to section 4.12.

Sec. 9. APPLICABILITY. This division of this Act 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.

DIVISION II

PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS AND WHOLESALE

DISTRIBUTION OF PRESCRIPTION DRUGS

Sec. 10. PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS AND WHOLESALE DISTRIBUTION OF PRESCRIPTION DRUGS —— REPORT.

1. By January 1, 2026, the commissioner of insurance, or the commissioner of insurance's designee, shall review pharmacy services administrative organizations and the wholesale distribution of prescription drugs, and submit a report to the general assembly containing the commissioner's findings and recommendations. The report shall include, at a minimum, all of the following:

a. A description and analysis of the prescription drug wholesale distribution supply chain, including the market concentration for the wholesale distribution of prescription drugs, margins in the wholesale distribution of prescription drugs, and the competition in the wholesale distribution of prescription drugs.

b. A description of the role that pharmacy services administrative organizations serve in the prescription drug supply chain.

c. A description and analysis of the relationships between pharmacy services administrative organizations, prescription drug wholesalers, and retail pharmacies, including but not limited to standard contracting terms, fees charged to pharmacies, and contractual restrictions and limitations applicable to retail pharmacies.

2. a. The commissioner of insurance shall submit the report under subsection 1 in a manner that does not publicly disclose any of the following:

(1) The identity of a specific pharmacy services administrative organization or prescription drug wholesaler.

(2) The price charged to a specific pharmacy for a specific prescription drug.

b. Information provided by the commissioner under this section that may reveal the identity of a specific pharmacy services administrative organization or prescription drug

wholesaler, or the price charged to a specific pharmacy for a specific prescription drug, shall be considered a confidential record.