State PBM Reform Inventory

Updated October 2026

Utah

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Department of Insurance to operate in the state. PBMs must submit an application form and an initial application fee designated by the department. Licenses are valid for 1 year	Utah Code § 31A-46-201; Utah Code § 31A-46-202
Reporting Requirements	Before April 1 of each year, a PBM operating in the state shall report to the department, for the previous calendar year: • Any insurer, pharmacy, or pharmacist in the state with which the PBM had a contract; • Total aggregate rebates and administrative fees that are attributable to enrollees of a contracting insurer; and • The percentage of aggregate rebates that the PBM retained under its agreement with the contracting insurer. A PBM may not enter or renew a contract with an insurer on or after January 1, 2021, to administer or manage rebate contracting or rebate administration unless the PBM agrees to regularly report to the insurer information regarding pharmaceutical manufacturer rebates received by the PBM under the contract. The information disclosed shall be detailed, claims-level data unless the PBM and insurer agree to waive this requirement.	Utah Code § 31A-46-301; Utah Code § 31A-46-307
PBM Income	**Rebate Pass-Through:** A health benefit plan renewed or entered on or after July 1, 2026, shall ensure that each pharmaceutical manufacturer rebate is used exclusively to benefit enrollees using one or multiple of the following methods: • Passing down the rebate at the point of sale to offset an enrollee's deductible or coinsurance; • Using the rebate to reduce premiums paid by the enrollee; or • Using the rebate to enhance enrollee health benefits.	Utah Code § 31A-22-643; Utah Code § 31A-46-312

	Spread Pricing: A PBM shall offer a self-funded health benefit plan, as an option for the self-funded health benefit plan's design, pharmacy benefit management services that: • Comply with the rebate pass-through requirements in s. 31A-22- 643; and • Do not include spread pricing.	
Pharmacy Contracting	**MAC Pricing:** A PBM shall not use MAC as a basis for reimbursement to a pharmacy unless: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and • The drug is generally available for purchase in this state and not obsolete. • For every drug which the PBM uses MAC to reimburse a contracted pharmacy, the pharmacy shall make a list available to a network pharmacy upon request in a format that is electronic, accessible, searchable, specifies MAC and NDC and identifies al drugs which MAC is established The MAC may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state. For every drug on a PBM's MAC list, the PBM shall: • Include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data; • Review and make necessary adjustments to the MAC at least once per week; • Provide a process for the contracted pharmacy to appeal the MAC; and • Include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible.	Utah Code § 31A-46-303; Utah Code § 31A-46-305; Utah Code § 31A-46-308

	The right to appeal shall be: • Limited to 21 days following initial claim adjudication; and • Investigated and resolved by the PBM within 14 business days. If an appeal is denied, the PBM shall provide the contracted pharmacy with the reason for the denial and the NDC of the drug that may be purchased by the pharmacy at a price at or below the price determined by the PBM. These requirements do not apply to a PBM providing pharmacy benefit management services on behalf of the Medicaid program. **Patient Steering:** A PBM shall reimburse a network pharmacy, in the aggregate, in an amount no less than the amount that the PBM reimburses an affiliate of the PBM in the same network, in the aggregate, for providing the same or equivalent pharmacy service. An insurer or PBM may not require a covered individual to obtain pharmacy services from an out-of-state mail-order pharmacy. This requirement does not apply if a prescription drug or device is not readily available in all retail pharmacies.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not require a covered individual to pay more than the lesser of the following for a covered prescription drug or device: • The applicable cost share of the prescription drug or prescription device being dispensed; • The applicable allowable claim amount of the prescription drug or prescription device being dispensed; • The applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or • The retail price of the prescription drug or prescription device without prescription drug coverage. **Copay Cap:** If a health benefit plan entered or renewed on or after January 1, 2021, provides coverage for insulin for diabetes, the health benefit plan shall:	Utah Code § 31A-46-302; Utah Code § 31A-22-626

	• Cap the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $30 per prescription of a 30-day supply of insulin for the treatment of diabetes; and • Apply the cap to an insured regardless of whether the insured has met the plan's deductible. This requirement does not apply to health benefit plans that: • Cover at least one insulin for the treatment of diabetes in each therapy category under the lowest tier of drugs; and • Do not require cost-sharing other than a copayment of an insured before the plan will cover insulin at the lowest tier. This requirement also does not apply to health benefit plans that: • Guarantee a covered individual shall not pay more out-of-pocket for insulin than if the insured would pay to obtain the insulin through the state's discount program described in Section 49-20- 421; and • Cap the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $100 per prescription of a 30-day supply of insulin for the treatment of diabetes. A health benefit plan may condition coverage of insulin using the above cost-sharing methods on: • The insured's participation in wellness-related activities for diabetes; • Purchasing a covered insulin product at an in-network pharmacy; or • Choosing an insulin from the plan's lowest formulary tier. The department shall annually update the applicable insulin copay caps to adjust for inflation and provide insurers with insulin pricing under the state's discount program.	