UTAH PHARMACY PREMIUM IMPACT SURVEY INSTRUCTIONS

All health insurers issuing comprehensive hospital & medical products in Utah's individual, small group, or large group markets are required to complete and file this annual survey. All other insurers are exempt. Send the completed survey form to the Utah Insurance Department (UID) by August 1, 2025. To submit your survey, you will need to have a UtahID account. If you do not have one already, you can find instructions on setting up your UtahID here (https://insurance.utah.gov/wp-content/uploads/CreatingYourUtahID.pdf). All submissions should be submitted to the UID secure file upload website at https://forms.uid.utah.gov/fileUploads/, selecting the **HEALTH RESEARCH DIVISION** option. Any other forms of data submissions are not acceptable. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code § 31A-2-308. Any questions on completing this survey form should be directed to the Research Analyst via email to uid.healthresearch@utah.gov. This survey is designed to meet the statutory requirements of Utah Code § 31A-48-103(2). All data values reported on the survey form should represent the year-end totals of the report year (December 31st). The purpose of this survey is to measure the impact of pharmacy drug costs on comprehensive hospital & medical premiums in Utah.

SIGNATURE FORM

The Utah Pharmacy Premium Impact Survey includes a business confidentiality signature form. The UID collects the Utah Pharmacy Premium Impact Survey with the intent and understanding that these records are classified as protected records under § 63G-2-305(2). The signature form is available from the website along with the survey form. The signature form should be filed along with the survey. This ensures that the data is properly classified as a protected record under § 63G-2-305(2). Please sign and date the signature form and return it to the UID. A copy will be kept on file along with your survey.

PART 1: UTAH PHARMACY DRUG COSTS

PHARMACY DRUG COSTS:
Benefits paid out under a policy's pharmacy benefit and/or paid claims for a prescription medical drug product with a National Drug Code issued by the FDA.

COMPREHENSIVE HOSPITAL & MEDICAL:
Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured member's primary health benefit plan. This category includes H16 Major Medical health benefit plans filed via SERFF as H16I, H16G, HOrg02I, or HOrg02G. Exclude all H15 Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (see Hosp-MedSurgical (Supplement Only)). Also, exclude all Short-Term Limited Duration plans (see Short-Term Limited Duration).

HOSP-MED-SURGICAL (SUPPLEMENT ONLY):
Business that includes any hospital only expense, medical only expense, surgical only expense, hospital and medical expense, hospital and surgical expense, medical and surgical expense, and hospital, medical and surgical expense (supplement). This category includes H15I or H15G Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (e.g., H16 Major Medical). Exclude all Comprehensive Hospital & Medical plans. Also, exclude all Short-Term Limited Duration plans.

SHORT-TERM LIMITED DURATION:
Business that complies with the definition of short-term limited duration plans under § 31A1-301(175). “Short-term limited duration health insurance” means a health benefit product that: (a) after taking into account any renewals and extensions, has a total duration of no more than 36 months; and (b) has an expiration date specified in the contract that is less than 12 months after the original effective date of coverage under the health benefit product. Short-term limited duration plans have limited medical benefits and are not considered a “health benefit plan” under Chapter 30 of the Utah Code. This category includes short-term limited duration plans filed via SERFF as H16I, H16G, H15I, or H15G product with a State Sub-TOI – Short Term. Exclude all Comprehensive Hospital & Medical plans or HospitalMedical-Surgical (Supplement Only) plans.

COLUMN DEFINITIONS

TOP 25 DRUGS BY SPENDING:
Utah Code § 31A-48-103(2)(a) requires insurers to report data for the 25 drugs which had the greatest spending, after adjusting for rebates.

Report the top 25 prescription drug products from both pharmacy and medical benefits that contributed the greatest dollar amounts to total annual spending. The list of drugs should be sorted and ranked by the greatest spending to the least spending (after adjusting for rebates), where #1 represents the greatest dollar amount of spending and #25 represents the least dollar amount of spending (out of the top 25 with greatest dollar amounts). “Drug spending” means the total allowable cost of the drug, before cost sharing, after adjusting for rebates.

NDC CODE:
The 11-digit national drug code (NDC) for each drug. This number identifies the labeler, product, and trade package size. Utah Code § 31A-48-103(2)(a) requires the insurer to report the strength and dosage of each drug. Reporting by 11-digit NDC code provides this information as the Insurance Department can use the NDC code to extract the product information, including the strength and dosage of the drug from the FDA database.

DRUG NAME:
The name of the prescription drug product that was sold to the member and was paid for by the insurer on the claim.

DRUG TYPE:
The drug classification under the health insurer’s formulary. The FDA classifies drugs as either Generic or Brand. If the insurer also classifies a drug as a specialty drug under their formulary, the drug should be broken out as a specialty drug for the purposes of the survey. Please select generic, brand or speciality in column 3 to classify each drug.

GENERIC:
Generic drugs as classified by the FDA. Exclude brand name drugs and specialty drugs

BRAND:
Brand name drugs as classified by the FDA. Exclude generic drugs and specialty drugs

SPECIALTY:
Generic or brand name drug classified as a specialty drug on the health insurer’s drug formulary list. Specialty drugs are prescription drug products that require special handling, have high costs,

or are only available through specialty pharmacies. Use the classification that is currently used during the report year on the health insurer's drug formulary list.

NUMBER OF PRESCRIPTIONS FILLED:
The number of unique drug claims received for the prescription drug during the reporting year. Count drug claims by unique dates of service. Each time a claim is filled under the prescription, it is counted as a "prescription". For example, a member who receives a 30-day supply of a drug each month has one doctor's prescription on file, but has filled the prescription once a month for twelve months. Count the twelve claims, rather than the one time the doctor issued a medical prescription for the patient.

NUMBER OF PERSONS:
The number of unique individual members who filed claims for the prescription drug during the reporting year. Count the number of insured members who received this drug during the reporting year. For example, a member who receives a 30-day supply of a drug each month would have twelve prescriptions filled. Count one member, rather than the twelve drug claims.

TOTAL DRUG SPENDING:
The allowable cost of the drug, before cost sharing, after adjusting for drug rebates. Total drug spending should be the total of the insurers' portion and the members' portion. In cases where the health insurer is not primary on the claim and the insurer paid less than the allowable, keep the insurers' paid amount and adjust the total allowable to match.

INSURERS' PORTION OF DRUG SPENDING:
Insurers' portion of drug spending" means the insurer cost after cost sharing, after adjusting for drug rebates. This is the portion of the total allowable cost paid by the insurer.

MEMBERS' PORTION OF DRUG SPENDING:
The member cost after cost sharing, after adjusting for drug rebates. This is the portion of the total allowable cost paid by the member.

PART 2: TOTAL HEALTH BENEFIT PLAN SPENDING DEFINITIONS

TOTAL HEALTH BENEFIT PLAN SPENDING:
All of the health care services paid for under a comprehensive hospital & medical health benefit plan. This is the total paid claims for the report year. Report all spending as the dollar amount for the allowable cost of the health care service before cost sharing, after adjusting for drug rebates. Include a breakout of the total insurer cost allowable (after cost sharing) and the member cost after adjusting for drug rebates (after cost sharing). .

TOTAL DIRECT EARNED PREMIUM:
The premium income received by the insurer from all sources (after risk adjustment) which was allocated to the insurer's loss experience, expenses, and profit during the report year. Report only direct earned premium for comprehensive hospital & medical health benefit plans.

TOTAL CUMULATIVE MEMBER MONTHS:
The cumulative year-end member months for all comprehensive hospital & medical business during the report year. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the

cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.