(g) "Qualified child" means an individual:

(i) who is under 18 years old;

(ii) whose household adjusted gross income is at or less than 300% of the federal poverty level;

(iii) is a United States citizen;

(iv) is a Utah resident;

(v) has been diagnosed with juvenile rheumatoid arthritis; and

(vi) is not eligible for Medicaid or the Children's Health Insurance Program.

(2) (a) Subject to appropriation and Subsection (2)(b), the department shall create a program to provide premium assistance to a qualified child.

(b) The department may not provide premium assistance to a qualified child if the qualified child has access to an optimal drug through a health benefit plan provided by the employer of the child's parent or guardian.

(3) An applicant for the premium assistance shall provide the department any information the department deems necessary to determine whether a child qualifies for the premium assistance.

(4) Each year, the department may not provide premium assistance to more than 150 qualified children.

(5) (a) The department shall provide the assistance directly to the eligible health benefit plan.

(b) The department may provide the premium assistance in the form of a lump sum payment.

(6) If a qualified child disenrolls from the eligible health benefit plan, the eligible health benefit plan shall return any funds provided by the department for the months that the qualified child was not enrolled in the eligible health benefit plan.

Ĥ→ (7) If a qualified child has the option to enroll in one of several eligible health benefit plans, the department shall, to the extent that is practicable, ensure that the number of qualified children receiving assistance under this section are divided evenly among eligible health benefit plans. ←Ĥ

Ĥ→ [~~(7)~~] (8) ←Ĥ In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules to implement this section.

Section 2. Section **31A-22-660** is enacted to read:

31A-22-660. Health benefit plan procedures related to prescription drugs.

(1) As used in this section, "long-term drug" means an enrollee's prescription drug where the prescription has been active for at least 180 days with the health benefit plan.