HB0052S01 compared with HB0052

~~{Omitted text}~~ shows text that was in HB0052 but was omitted in HB0052S01
inserted text shows text that was not in HB0052 but was inserted into HB0052S01

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Health Insurance Modifications

2025 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Candice B. Pierucci

Senate Sponsor:

LONG TITLE

General Description:

This bill enacts provisions related to health insurance.

Highlighted Provisions:

This bill:

- defines terms; {~~and~~}
- requires {~~a health benefit plan~~ } an insurer to {~~count all payments paid~~ } calculate drug or device discount coupons on behalf of an {~~enrollee~~ } individual towards the {~~enrollee's deductible.~~ } individual's cost sharing requirement unless certain circumstances are met;
- **requires a entity that provides a drug or device discount coupon to allow the full amount of the coupon amount to be used for the drug or device; and**
- **provides an exception to the requirements for a qualifying health benefit plan.**

Money Appropriated in this Bill:

None

None

ENACTS:

HB0052

~~{31A-22-622 , Utah Code Annotated 1953 , Utah Code Annotated 1953}~~

31A-22-662 , Utah Code Annotated 1953 , Utah Code Annotated 1953

31A-48-104 , Utah Code Annotated 1953 , Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **1** is enacted to read:

31A-22-622. Cost sharing requirements for health benefit plans.

(1) As used in this section:

(a)

(i) "Cost sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing required by a health benefit plan for a specific health care service covered by the health benefit plan.

(ii) "Cost sharing requirement" includes any copayment, coinsurance, deductible, or annual limitation that is subject to 42 U.S.C. Secs. 18022(c) or 300gg-6(b).

(b)

(i) "Health care service" means an item or service furnished to an individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(ii) "Health care service" includes a prescription drug.

(2) When calculating an enrollee's contribution to any applicable cost sharing requirement for a health care service, an insurer shall include any cost sharing amounts paid:

(a) by the enrollee; or

(b) on behalf of the enrollee by another person.

(3) This section applies to any health benefit plan entered into, amended, extended, or renewed on or after January 1, 2026.

(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

(5) This section does not apply to a health care service that is a prescription drug if:

(a) there is a medically appropriate generic equivalent; and

(b) the patient's doctor has indicated that the medically appropriate generic equivalent is appropriate for the patient.

Section 1. Section **1** is enacted to read:

31A-22-662. Cost sharing requirements for health benefit plans.

(1) As used in this section:

(a)

(i) "Cost sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost sharing required by a health benefit plan for a specific health care service covered by the health benefit plan.

(ii) "Cost sharing requirement" includes any copayment, coinsurance, deductible, or annual limitation that is subject to 42 U.S.C. Sec. 18022(c) or 300gg-6(b).

(b) "Qualifying health benefit plan" means a health benefit plan that:

(i) allows the full value of available copay assistance to reduce the out-of-pocket costs of an enrollee;

(ii) includes, when two or more individuals are covered, an individual maximum out-of-pocket that is not greater than 50% of the health benefit plan's combined total maximum out-of-pocket for family coverage;

(iii) after the deductible has been met, only requires payment by the enrollee at the equivalent of the plan's lowest payment tier for any drug that has been subject to copay assistance and that copay assistance has been exhausted; and

(iv) for a covered lower cost drug that an enrollee is required to take under the plan instead of a covered higher cost drug for which copay assistance reduces the enrollee's out-of-pocket costs to a negligible amount, the plan:

(A) only requires payment by the enrollee of the preferred drug at the equivalent of the plan's lowest payment tier; and

(B) may share cost savings due to the lower cost drug with the enrollee, including while the enrollee is subject to a deductible.

(2) Except as provided in Subsection (3), when calculating an enrollee's contribution to any applicable cost sharing requirement for a covered prescription drug or device, an insurer shall include any cost sharing amounts paid:

(a) by the enrollee; or

(b) using a drug discount coupon.

(3) An insurer may refuse to apply a drug discount coupon to an enrollee's applicable cost sharing requirement for the drug or device that is eligible for the drug discount coupon if:

(a) the drug or device that is eligible for the drug discount coupon has:

(i) a generic alternative; or

(ii) a biological product, as defined in 42 U.S.C. Sec. 262, that:

(A) has been approved by the federal Food and Drug Administration to treat the enrollee's condition;

(B) is not eligible for a drug discount coupon; and

(C) is subject to the health benefit plan's lowest copay tier for biologic products; or

(b) the enrollee has not obtained a necessary approval from the health benefit plan to have the drug covered by the health benefit plan or has not completed the necessary requirements, restrictions, or clinical criteria to obtain the approval.

(4) This section:

(a) applies to any health benefit plan entered into, amended, extended, or renewed on or after July 1, 2026; and

(b) does not apply to a qualifying health benefit plan.

(5) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

Section 2. Section **2** is enacted to read:

31A-48-104. Drug discount coupon requirements.

(1) As used in this section, "cost sharing requirement" means the same as that term is defined in Section 31A-22-662.

(2) A pharmaceutical manufacturer or other entity that provides a drug discount coupon with the expectation that the drug discount coupon will be applied toward an enrollee's cost sharing requirement:

(a) shall allow an insurer, complying with Section 31A-22-662, to utilize the full value of the drug discount coupon:

(i) first to reduce the enrollee's cost sharing requirement, including the enrollee's maximum out-of-pocket expense, at the point of sale; and

(ii) for any remainder, to lower the cost of the prescription drug or device;

(b) shall disclose to the insurer the terms and conditions associated with the drug discount coupon; and

(c) may not modify the terms and conditions associated with the drug discount coupon on the basis that it is redeemed by an enrollee of the health benefit plan that is complying with Section 31A-22-662.

Section 3. **Effective date.**

This bill takes effect on May 7, 2025.

HB0052 compared with HB0052S01

2-5-25 7:38 AM