Effective 1/1/2021

31A-22-626 Coverage of diabetes.

(1) As used in this section:

(a) "Diabetes" includes individuals with:

(i) complete insulin deficiency or type 1 diabetes;

(ii) insulin resistant with partial insulin deficiency or type 2 diabetes; or

(iii) elevated blood glucose levels induced by pregnancy or gestational diabetes.

(b) "High deductible health plan" means the same as that term is defined in Section 223(c)(2), Internal Revenue Code.

(c) "Lowest tier" means:

(i) the lowest cost tier of a health benefit plan;

(ii) the lowest cost-sharing level of a high deductible health plan that preserves the enrollee's ability to claim tax exempt contributions from the enrollee's health savings account under federal laws and regulations; or

(iii) a discount or other cost-savings program that has the effect of equating cost-sharing of insulin to the health plan's lowest-cost tier.

(d) "Therapy category" means a type of insulin that is distinct from other types of insulin due to a difference in onset, peak time, or duration.

(2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes for accident and health insurance policies that provide a health insurance benefit before July 1, 2000.

(3) In making rules under Subsection (2), the commissioner shall require rules:

(a) with durational limits, amount limits, deductibles, and coinsurance for the treatment of diabetes equitable or identical to coverage provided for the treatment of other illnesses or diseases; and

(b) that provide coverage for:

(i) diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by an attending physician within the plan and consistent with the health plan provisions for self-management education:

(A) recognized by the federal Centers for Medicare and Medicaid Services; or

(B) certified by the Department of Health; and

(ii) the following equipment, supplies, and appliances to treat diabetes when medically necessary:

(A) blood glucose monitors, including those for the legally blind;

(B) test strips for blood glucose monitors;

(C) visual reading urine and ketone strips;

(D) lancets and lancet devices;

(E) insulin;

(F) injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems;

(G) syringes;

(H) prescriptive oral agents for controlling blood glucose levels; and

(I) glucagon kits.

(4) If a health benefit plan entered into or renewed on or after January 1, 2021, provides coverage for insulin for diabetes, the health benefit plan shall:

(a) 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
(b) apply the cap to an insured regardless of whether the insured has met the plan's deductible.
(5) Subsection (4) does not apply to a health benefit plan that:
(a) covers at least one insulin for the treatment of diabetes in each therapy category under the lowest tier of drugs; and
(b) does not require cost-sharing other than a co-payment of an insured before the plan will cover insulin at the lowest tier.
(6) Subsection (4) does not apply to a health benefit plan that:
(a) guarantees an insured that the insured will not pay more out-of-pocket for insulin the insured obtains through the health benefit plan than the insured would pay to obtain insulin through the discount program described in Section 49-20-421; and
(b) caps 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.
(7) A health benefit plan that provides coverage for insulin may condition the coverage of insulin at a cost-sharing method described in Subsection (4), (5), or (6) on:
(a) the insured's participation in wellness-related activities for diabetes;
(b) purchasing the insulin at an in-network pharmacy; or
(c) choosing an insulin from the lowest tier of the health benefit plan's formulary.
(8) The department may issue a waiver from the requirements described in Subsection (4) to a health benefit plan if the health benefit plan can demonstrate to the department that the plan provides an insured with substantially similar consumer cost reductions to those that result from Subsections (4) and (5).
(9) The department shall annually adjust the caps described in Subsections (4)(a) and (6)(b) for inflation based on an index that reflects the change in the previous year in the average wholesale price of insulin sold in Utah.
(10) The department shall annually provide the price of insulin available under the discount program described in Section 49-20-421 to a health benefit plan that adopts the cost-sharing method described in Subsection (6).
(11) A health benefit plan entered into or renewed on or after January 1, 2021, that provides coverage of insulin is not required to reimburse a participant, as that term is defined in Subsection 49-20-421(1), for insulin the participant obtains through the discount program described in Section 49-20-421.
(12) The department may request information from insurers to monitor the impact of the requirements of this section on insulin prices charged by pharmaceutical manufacturers.
(13) The department shall classify records provided in response to the request described in Subsection (12) as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.
(14) The department may not publish information submitted in response to the request described in Subsection (12) in a manner that:
(a) makes a specific submission from a contracting insurer identifiable; or
(b) discloses information that is a trade secret, as defined in Section 13-24-2.

Amended by Chapter 310, 2020 General Session