Part 4
Insurance Program

49-20-401 Program -- Powers and duties.

(1) The program shall:

(a) act as a self-insurer of employee benefit plans and administer those plans;

(b) enter into contracts with private insurers or carriers to underwrite employee benefit plans as considered appropriate by the program;

(c) indemnify employee benefit plans or purchase commercial reinsurance as considered appropriate by the program;

(d) provide descriptions of all employee benefit plans under this chapter in cooperation with covered employers;

(e) process claims for all employee benefit plans under this chapter or enter into contracts, after competitive bids are taken, with other benefit administrators to provide for the administration of the claims process;

(f) obtain an annual actuarial review of all health and dental benefit plans and a periodic review of all other employee benefit plans;

(g) consult with the covered employers to evaluate employee benefit plans and develop recommendations for benefit changes;

(h) annually submit a budget and audited financial statements to the governor and Legislature that includes total projected benefit costs and administrative costs;

(i) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the employee benefit plans as certified by the program's consulting actuary;

(j) submit, in advance, the program's recommended benefit and rate adjustments for state employees, which may include actuarially substantiated member premium differentials between networks to:

(i) the Legislature; and

(ii) the director of the state Division of Human Resource Management;

(k) determine benefits and rates, upon approval of the board, for multi-employer risk pools, retiree coverage, and conversion coverage;

(l) determine benefits and rates based on the total estimated costs and the employee premium share established by the Legislature, upon approval of the board, for state employees;

(m) administer benefits and rates, upon ratification of the board, for single-employer risk pools;

(n) request proposals for one or more out-of-state provider networks and a dental health plan administered by a third-party carrier at least once every three years for the purposes of:

(i) stimulating competition for the benefit of covered individuals;

(ii) establishing better geographical coverage of medical care services; and

(iii) providing coverage for both active and retired covered individuals;

(o) for a proposal that meets the criteria specified in a request for proposals and is accepted by the program:

(i) offer the proposal to active and retired state-covered individuals; and

(ii) at the option of the covered employer, offer the proposal to active and retired covered individuals of other covered employers;

(p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for the Department of Health and Human Services if the program provides program benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26B, Chapter 3, Part 9, Utah Children's Health Insurance Program;

(q) establish rules and procedures governing the admission of political subdivisions or educational institutions and their employees to the program;

(r)

(i) contract directly with medical providers to provide services for covered individuals at commercially competitive rates; and

(ii)

(A) discontinue the preferred network, which offers in-network access to all in-state hospitals, for the state risk pool created in Subsection 49-20-202(1)(a) for plan years starting on or after July 1, 2022; and

(B) for an employee in the state risk pool who fails to elect one of the remaining networks before July 1, 2022, enroll the employee and the employee's dependents into the network that best reflects the utilization pattern of that employee and the employee's dependents;

(s)

(i) require state employees and the state employees' dependents to participate in the electronic exchange of clinical health records in accordance with Section 26B-8-411 unless the enrollee opts out of participation; and

(ii) prior to enrolling the state employee, each time the state employee logs onto the program's website, and each time the enrollee receives written enrollment information from the program, provide notice to the enrollee of the enrollee's participation in the electronic exchange of clinical health records and the option to opt out of participation at any time;

(t) at the request of a procurement unit, as that term is defined in Section 63G-6a-103, that administers benefits to program recipients who are not covered by Title 26B, Utah Health and Human Services Code, provide services for:

(i) drugs;

(ii) medical devices; or

(iii) other types of medical care; and

(u) take additional actions necessary or appropriate to carry out the purposes of this chapter.

(2)

(a) Funds budgeted and expended shall accrue from rates paid by the covered employers and covered individuals.

(b) The board shall approve administrative costs and report the administrative costs to the governor and the Legislature.

(3) The Division of Human Resource Management shall include the benefit and rate adjustments described in Subsection (1)(j) in the total compensation plan recommended to the governor required under Subsection 63A-17-307(5)(a).

(4) The program may establish a partnership with a public entity in a different state to purchase or share services related to the administration of medical benefits if:

(a) the program receives approval for the partnership from the board; and

(b) the partnership:

(i) creates cost savings for Utah;

(ii) does not commingle state funds with funds of the public entity in the other state; and

(iii) does not pose a greater actuarial risk to Utah than the program has already assumed.

Amended by Chapter 194, 2023 General Session
Amended by Chapter 328, 2023 General Session

49-20-402 Reserves to be held -- Refunds.

(1) The reserves in a risk pool in a given fiscal year shall be maintained at the level recommended by the program's consulting actuary and approved or ratified by the board. If the reserves drop below that level, covered employers in the risk pool are required to cure any deficiency in the reserve.
(2) If substantial excess reserves are accrued above those required by this chapter, and the board determines that a refund is appropriate, a refund shall be made:
(a) to covered employers which shall then make a refund to covered individuals on the basis of the contribution of each to the plan; or
(b) directly to covered individuals on the basis of the contribution of each to the plan.

Amended by Chapter 130, 2007 General Session

49-20-403 Assistance to members in purchase of life, health, dental, and medical insurance after retirement -- Employment of personnel to administer section.
(1) The program may assist active and retired covered individuals and inactive covered individuals of the covered employers to purchase life, health, dental, and medical coverage on a group basis which can be continued after retirement under rules adopted by the board.
(2) The executive director may employ any personnel, including consultants, to administer this section.

Enacted by Chapter 250, 2002 General Session

49-20-404 Governors' and legislative paid-up group health coverage benefit -- Limitations -- Medicare supplemental coverage -- Spouse coverage -- Limitations.
(1)
(a) Except as provided under Subsection (1)(b), the state shall pay the percentage of the cost of providing paid-up group health coverage under Subsection (3) for members and their surviving spouses covered under Chapter 19, Utah Governors' and Legislators' Retirement Act, or governors and legislators, as defined in Section 49-19-102, and their surviving spouses covered under Chapter 22, New Public Employees' Tier II Contributory Retirement Act, who:
(i) retire after January 1, 1998;
(ii) are at least 62 but less than 65 years of age;
(iii) elect to receive and apply for this benefit to the program; and
(iv) are active members at the time of retirement or have continued coverage with the program until the date of eligibility for the benefit under this Subsection (1).
(b) A governor or a legislator who begins service as a governor or legislator on or after January 1, 2012, and a surviving spouse of the governor or the legislator who begins service as a governor or legislator on or after January 1, 2012, is not eligible for the benefit provided under this Subsection (1).
(2) The state shall pay the percentage of the cost of providing Medicare supplemental coverage under Subsection (3) for members and their surviving spouses covered under Chapter 19, Utah Governors' and Legislators' Retirement Act who:
(a) began service as a governor or legislator before July 1, 2013;
(b) retire after January 1, 1998;
(c) are at least 65 years of age; and
(d) elect to receive and apply for this benefit to the program.
(3) The following percentages apply to the benefit described in Subsections (1)(a) and (2):

(a) 100% if the member has accrued 10 or more years of service credit;
(b) 80% if the member has accrued 8 or more years of service credit;
(c) 60% if the member has accrued 6 or more years of service credit; and
(d) 40% if the member has accrued 4 or more years of service credit.

Amended by Chapter 410, 2013 General Session

49-20-405 Audit required -- Report to governor and Legislature.

The Insurance Department shall biennially audit the Public Employees' Trust Fund and programs authorized under this chapter and report its findings to the governor and the Legislature, but the commissioner may accept the annual audited statement of the programs under this chapter in lieu of the biennial audit requirement.

Renumbered and Amended by Chapter 250, 2002 General Session

49-20-406 Insurance benefits for employees' beneficiaries.

(1) As used in this section:
(a) "Children" includes stepchildren and legally adopted children.
(b)
(i) "Line-of-duty death" means a death resulting from:
(A) external force or violence occasioned by an act of duty as an employee; or
(B) strenuous activity, including a heart attack or stroke, that occurs during strenuous training or another strenuous activity required as an act of duty as an employee.
(ii) "Line-of-duty death" does not include a death that:
(A) occurs during an activity that is required as an act of duty as an employee if the activity is not a strenuous activity, including an activity that is clerical, administrative, or of a nonmanual nature contributes to the employee's death;
(B) occurs during the commission of a crime committed by the employee;
(C) the employee's intoxication or use of alcohol or drugs, whether prescribed or nonprescribed, contributes to the employee's death; or
(D) occurs in a manner other than as described in Subsection (1)(b)(i).
(c)
(i) "Strenuous activity" means engagement involving a difficult, stressful, or vigorous fire suppression, rescue, hazardous material response, emergency medical service, physical law enforcement, prison security, disaster relief, or other emergency response activity.
(ii) "Strenuous activity" includes participating in a participating employer sanctioned and funded training exercise that involves difficult, stressful, or vigorous physical activity.
(2) The beneficiary of a covered individual who is employed by the state and who has a line-of-duty death shall receive:
(a) the proceeds of a $50,000 group term life insurance policy paid for by the state and administered and provided as part of the group life insurance program under this chapter; and
(b) group health coverage paid for by the state that covers the covered individual's:
(i) surviving spouse until becoming eligible for Medicare as long as the surviving spouse continues coverage with the program; and
(ii) unmarried children up to the age of 26.
(3) A covered employer not required to provide the benefits under Subsection (2) may provide either or both of the benefits under Subsection (2) by paying rates established by the program.

(4) The benefit provided under Subsection (2)(a) is subject to the same terms and conditions as the group life insurance program provided under this chapter.

Amended by Chapter 210, 2018 General Session

49-20-407 Insurance mandates.

Notwithstanding the provisions of Subsection 31A-1-103(3)(f):

(1) health coverage offered to the state employee risk pool under Subsection 49-20-202(1)(a) shall comply with the provisions of Sections 31A-22-605.5 and 31A-45-501; and

(2) a health plan offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b) shall comply with the provisions of Section 31A-22-605.5.

Amended by Chapter 292, 2017 General Session

49-20-408 Prohibition against certain uses of Social Security numbers.

Notwithstanding the provisions of Subsection 31A-1-103(3)(f), health, dental, medical, Medicare supplement, or conversion coverage offered under Section 49-20-202 shall comply with the provisions of Section 31A-22-634.

Enacted by Chapter 188, 2003 General Session

49-20-409 Long-term disability -- Cost of health coverage benefit.

(1) Under the direction of the board, the program shall provide for health insurance coverage for state employees who receive a monthly disability benefit under Title 49, Chapter 21, Public Employees' Long-Term Disability Act.

(2) A risk pool, other than the state risk pool, may elect to provide a benefit for its employees similar to the benefit provided under Subsection (1).

Amended by Chapter 130, 2007 General Session

49-20-410 High deductible health plan -- Health savings account -- Contributions.

(1)

(a) In addition to other employee benefit plans offered under Subsection 49-20-201(1), the office shall offer at least one federally qualified high deductible health plan with a health savings account as an optional health plan.

(b) The provisions and limitations of the plan shall be:

(i) determined by the office in accordance with federal requirements and limitations; and

(ii) designed to promote appropriate health care utilization by consumers, including preventive health care services.

(c) A state employee hired on or after July 1, 2011, who is offered a plan under Subsection 49-20-202(1)(a), shall be enrolled in a federally qualified high deductible health plan unless the employee chooses a different health benefit plan during the employee's open enrollment period.

(2) The office shall:

(a) administer the high deductible health plan in coordination with a health savings account for medical expenses for each covered individual in the high deductible health plan;

(b) offer to all employees training regarding all health plans offered to employees;

(c) prepare online training as an option for the training required by Subsections (2)(b) and (4);
(d) ensure the training offered under Subsections (2)(b) and (c) includes information on changing coverages to the high deductible plan with a health savings account, including coordination of benefits with other insurances, restrictions on other insurance coverages, and general tax implications; and
(e) coordinate annual open enrollment with the Division of Human Resource Management to give state employees the opportunity to affirmatively select preferences from among insurance coverage options.

(3)
(a) Contributions to the health savings account may be made by the employer.
(b) The amount of the employer contributions under Subsection (3)(a) shall be determined annually by the office, after consultation with the Division of Human Resource Management and the Governor's Office of Planning and Budget so that the annual employer contribution amount is not less than the difference in the actuarial value between the program's health maintenance organization coverage and the federally qualified high deductible health plan coverage, after taking into account any difference in employee premium contribution.
(c) The office shall distribute the annual amount determined under Subsection (3)(b) to employees in two equal amounts with a pay date in January and a pay date in July of each plan year.
(d) An employee may also make contributions to the health savings account.
(e) If an employee is ineligible for a contribution to a health savings account under federal law and would otherwise be eligible for the contribution under Subsection (3)(a), the contribution shall be distributed into a health reimbursement account or other tax-advantaged arrangement authorized under the Internal Revenue Code for the benefit of the employee.

(4)
(a) An employer participating in a plan offered under Subsection 49-20-202(1)(a) shall require each employee to complete training on the health plan options available to the employee.
(b) The training required by Subsection (4)(a):
(i) shall include materials prepared by the office under Subsection (2);
(ii) may be completed online; and
(iii) shall be completed:
(A) before the end of the 2012 open enrollment period for current enrollees in the program; and
(B) for employees hired on or after July 1, 2011, before the employee's selection of a plan in the program.

Amended by Chapter 344, 2021 General Session
Amended by Chapter 382, 2021 General Session

49-20-413 Pilot program for on-site employee clinic.

(1) Within state premiums paid to the state risk pool from the Legislature, the program shall establish a primary care clinic:
(a) for state employees and their dependents;
(b) within a state building that is accessible to a large number of state employees; and
(c) in accordance with Subsection (2).

(2) The program shall:
(a) affiliate with an existing clinic:
(i) located in a building accessible to a large number of state employees; and

(ii) managed by a physician licensed in this state under Title 58, Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act; or

(b) request bids from private entities to establish the on-site primary care clinic in accordance with criteria established by the program, which shall include at least the following:

(i) the entity's ability to establish a primary care clinic that is designed to:

(A) be convenient for employees and their dependents;

(B) increase health of employees;

(C) increase compliance with health care screening and management of chronic health care conditions; and

(D) dispense commonly used, pre-packaged drugs in a cost effective manner;

(ii) the entity's organizational and financial independence from any particular hospital network, network of clinics, or network of health care providers; and

(iii) management of the clinic by a physician licensed in the state under Title 58, Chapter 67, Utah Medical Practice Act, or Chapter 68, Utah Osteopathic Medical Practice Act.

Enacted by Chapter 68, 2015 General Session

49-20-414 Telemedicine services -- Reimbursement -- Reporting.

(1) As used in this section:

(a) "Network provider" means a health care provider who has an agreement with the program to provide health care services to a patient with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the managed care organization.

(b) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(2) This section applies to the risk pool established for the state under Subsection 49-20-201(1)(a).

(3) The program shall, at the provider's request, reimburse a network provider for medically appropriate telemedicine services at a commercially reasonable rate.

(4) Before November 1, 2019, the program shall report to the Legislature's Public Utilities, Energy, and Technology Interim Committee and Health Reform Task Force on:

(a) the result of the reimbursement requirement described in Subsection (3);

(b) existing and potential uses of telehealth and telemedicine services;

(c) issues of reimbursement to a provider offering telehealth and telemedicine services;

(d) potential rules or legislation related to:

(i) providers offering and insurers reimbursing for telehealth and telemedicine services; and

(ii) increasing access to health care, increasing the efficiency of health care, and decreasing the costs of health care; and

(e) telemedicine services that the program declined to cover because the telemedicine services that were requested were not medically appropriate.

Amended by Chapter 328, 2023 General Session

Effective until 5/1/2024

49-20-415 Prescribing policies for certain opioid prescriptions.

A plan offered to state employees under this chapter may implement a prescribing policy for certain opioid prescriptions in accordance with Section 31A-22-615.5.

Enacted by Chapter 53, 2017 General Session

Effective 5/1/2024

49-20-415 Prescribing policies for certain opioid prescriptions.

A plan offered to state employees under this chapter may implement a prescribing policy for certain opioid prescriptions.

49-20-416 Screening, Brief Intervention, and Referral to Treatment program reimbursement.

(1) As used in this section:

(a) "Controlled substance prescriber" means a controlled substance prescriber, as that term is defined in Section 58-37-6.5, who:

(i) has a record of having completed SBIRT training, in accordance with Subsection 58-37-6.5(2), before providing the SBIRT services; and

(ii) is a program enrolled controlled substance prescriber.

(b) "SBIRT" means the same as that term is defined in Section 58-37-6.5.

(2) The health program offered to the state employee risk pool under Section 49-20-202 shall reimburse a controlled substance prescriber who provides SBIRT services to a covered individual who is 13 years of age or older for the SBIRT services.

Enacted by Chapter 180, 2017 General Session

49-20-417 Insurance coverage for amino acid-based formula.

(1) As used in this section:

(a) "Amino acid-based elemental formula" means a nutrition formula:

(i) made from individual nonallergenic amino acids that are broken down to enhance absorption and digestion; and

(ii) designed for individuals who have a dysfunctional or shortened gastrointestinal tract and are unable to tolerate and absorb whole foods or formulas composed of whole proteins, fats, or carbohydrates.

(b) "Eosinophilic gastrointestinal disorder" means a disorder characterized by having above normal amounts of eosinophils in one or more specific places anywhere in the digestive system.

(c) "Food protein-induced enterocolitis syndrome" means a disorder characterized by an abnormal immune response to an ingested food, resulting in gastrointestinal inflammation.

(d) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).

(e) "Order" means to communicate orally, in writing, or by electronic means.

(f) "Pharmacy" means a pharmacy licensed under Title 58, Chapter 17b, Pharmacy Practice Act.

(g) "Physician" means an individual who is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(h) "Program" means the eosinophilic gastrointestinal disorder program created in Subsection (2).

(i) "Severe protein allergic conditions" includes:

(i) eosinophilic esophagitis;

(ii) eosinophilic gastritis;

(iii) eosinophilic gastroenteritis;

(iv) eosinophilic enteritis;

(v) eosinophilic colitis; or

(vi) food protein-induced enterocolitis syndrome.

(j) "Short bowel syndrome" means malabsorption of nutrients resulting from anatomical or functional loss of a significant length of the small intestine.

(2) Beginning plan year 2017-18 and ending plan year 2019-20, the Public Employees' Benefit and Insurance Program shall offer a 3-year pilot program within the state risk pool that provides coverage for the use of an amino acid-based elemental formula, regardless of the delivery method of the formula, for the diagnosis or treatment of an eosinophilic gastrointestinal disorder, food protein-induced enterocolitis syndrome, severe protein allergic condition, or short bowel syndrome in the traditional and Star plans.
(3) Coverage offered under Subsection (2) applies to an amino acid-based elemental formula if:
  (a) the formula is ordered for the enrollee by a physician;
  (b) the physician indicates in the order that the formula is medically necessary; and
  (c) the insured obtains the formula from a pharmacy.
(4) Coverage offered under Subsection (2) may not include cost-sharing provisions, including deductibles, copayments, co-insurance, and out-of-pocket limits, or a durational limit, that are less favorable to the insured than the cost-sharing provisions and durational limits applied by the health benefit plan to prescription drugs.
(5) The purpose of the program is to study the efficacy of providing coverage for the use of an amino acid-based elemental formula and is not a mandate for coverage of an amino acid-based elemental formula within the health plans offered by the Public Employees' Benefit and Insurance Program.
(6) Under Section 63J-1-603 of the Utah Code, the Legislature intends that the cost of the program shall be paid for from funds above the minimum recommended level in the public employees' state risk pool reserve.

Enacted by Chapter 349, 2017 General Session

Effective until 7/1/2024

49-20-418 Expanded infertility treatment coverage pilot program.

(1) As used in this section:
  (a) "Assisted reproductive technology" means the same as the term is defined in 42 U.S.C. Sec. 263a-7.
  (b) "Physician" means the same as the term is defined in Section 58-67-102.
  (c) "Pilot program" means the expanded infertility treatment coverage pilot program described in Subsection (2).
  (d) "Qualified assisted reproductive technology cycle" means the use of assisted reproductive technology to transfer a single embryo for implantation.
  (e) "Qualified individual" means a covered individual who is eligible for maternity benefits under the program.
(2)
  (a) Beginning plan year 2018-19, and ending plan year 2023-24, the program shall offer a pilot program within the state risk pool that provides coverage to a qualified individual for the use of an assisted reproductive technology.
  (b)
    (i) For plan year 2018-19, 2019-20, or 2020-21, the pilot program shall offer a one-time benefit of $4,000 toward the costs of using an assisted reproductive technology for each qualified individual.
    (ii) For plan year 2021-22, 2022-23, or 2023-24, the pilot program shall offer a benefit of $4,000 to a qualified individual toward the costs of each qualified assisted reproductive technology cycle.

(c) The benefits described in Subsection (2)(b) are subject to the same cost sharing requirements as the covered individual's plan.

(3) Coverage offered under the pilot program applies if:

(a) the patient who will use the assisted reproductive technology is a qualified individual;

(b)

(i) the patient's physician verifies that the patient or the patient's spouse has a demonstrated condition recognized by a physician as a cause of infertility; or

(ii) the patient attests that the patient is unable to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;

(c) the patient attests that the patient has been unable to attain a successful pregnancy through any less-costly, potentially effective infertility treatments for which coverage is available under the health benefit plan; and

(d) the use of the assisted reproductive technology procedure is performed at a medical facility that conforms to the minimal standards for programs of assisted reproductive technology procedures adopted by the American Society for Reproductive Medicine.

(4) Coverage offered under the pilot program:

(a) shall satisfy, in accordance with Subsection 31A-22-610.1(1)(c)(ii), the requirement to provide an adoption indemnity benefit to a qualified individual under Section 31A-22-610.1;

(b) does not apply to a qualified individual if the qualified individual has received the adoption indemnity benefit required under Section 31A-22-610.1; and

(c) for plan year 2021-22, 2022-23, or 2023-24, shall apply to a qualified individual, even if the qualified individual received the benefit described in Subsection (2)(b)(i).

(5)

(a) The purpose of the pilot program is to study the efficacy of providing coverage for the use of an assisted reproductive technology and is not a mandate for coverage of an assisted reproductive technology within all health plans offered by the program.

(b) The program shall report to the Retirement and Independent Entities Interim Committee regarding the costs and benefits of the pilot program:

(i) on or before October 1; and

(ii) during calendar years 2022 and 2023.

(6) Under Section 63J-1-603, the Legislature intends that the cost of the pilot program will be paid from money above the minimum recommended level in the public employees' state risk pool reserve.

Amended by Chapter 64, 2021 General Session
Amended by Chapter 195, 2021 General Session

Effective 7/1/2024

49-20-418 Expanded infertility treatment benefit.

(1) As used in this section:

(a) "Assisted reproductive technology" means the same as the term is defined in 42 U.S.C. Sec. 263a-7.

(b) "Physician" means the same as the term is defined in Section 58-67-102.

(c) "Qualified assisted reproductive technology cycle" means the use of assisted reproductive technology to transfer a single embryo for implantation.

(d) "Qualified individual" means an individual:

(i) covered within the state risk pool; and

(ii) eligible for maternity benefits under the program.

(2)
(a) The program shall offer a benefit of $4,000 to a qualified individual toward the costs of each qualified assisted reproductive technology cycle.
(b) The benefit is subject to the same cost sharing requirements as the qualified individual's plan.
(3) A qualified individual shall receive the benefit described in Subsection (2) if:
(a) the qualified individual is the patient who will use the assisted reproductive technology;
(b)
(i) the patient's physician verifies that the patient or the patient's spouse has a demonstrated condition recognized by a physician as a cause of infertility; or
(ii) the patient attests that the patient is unable to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;
(c) the patient attests that the patient has been unable to attain a successful pregnancy through any less-costly, potentially effective infertility treatments for which coverage is available under the health benefit plan; and
(d) the use of the assisted reproductive technology procedure complies with the program's clinical policies and is performed at a medical facility that conforms to the minimal standards for programs of assisted reproductive technology procedures adopted by the American Society for Reproductive Medicine.
(4)
(a) The provision of a benefit in accordance with this section shall satisfy, in accordance with Subsection 31A-22-610.1(1)(c)(ii), the requirement to provide an adoption indemnity benefit to a qualified individual under Section 31A-22-610.1.
(b) If a qualified individual has received the adoption indemnity benefit required under Section 31A-22-610.1, the qualified individual may not receive a benefit in accordance with this section.

49-20-419 Coverage of exome sequence testing.
(1) As used in this section, "exome sequence testing" means a genomic technique for sequencing the genome of an individual for diagnostic purposes.
(2) Beginning July 1, 2019, the program shall provide coverage for exome sequence testing:
(a) for a covered individual within the state risk pool who:
(i) is younger than 21 years of age; and
(ii) who remains undiagnosed after exhausting all other appropriate diagnostic-related tests;
(b) performed by a nationally recognized provider with significant experience in exome sequence testing;
(c) that is medically necessary; and
(d) at a rate set by the program.

Enacted by Chapter 320, 2019 General Session

49-20-420 Coverage for in vitro fertilization and genetic testing.
(1) As used in this section:
(a) "Qualified condition" means:
(i) cystic fibrosis;
(ii) spinal muscular atrophy;
(iii) Morquio Syndrome;
(iv) myotonic dystrophy; or

(v) sickle cell anemia.
(b) "Qualified individual" means a covered individual who:
(i) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and
(ii) intends to get pregnant with a partner who is diagnosed by a physician as having a genetic trait associated with the same qualified condition as the covered individual.
(2) For a plan year that begins on or after July 1, 2020, the program shall provide coverage for a qualified individual for:
(a) in vitro fertilization services; and
(b) genetic testing of a qualified individual who receives in vitro fertilization services under Subsection (2)(a).
(3) Before November 1, 2022, and before November 1 of every third year thereafter, the program shall:
(a) calculate the change in state spending attributable to the coverage under this section; and
(b) report the amount described in Subsection (3)(a) to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee.

Enacted by Chapter 187, 2020 General Session

49-20-421 Prescription discount program.
(1) As used in this section:
(a) "Discount program" means the prescription discount program created by this section.
(b) "Epinephrine auto-injector" means the same as that term is defined in Section 26B-4-401.
(c) "Insulin" means a prescription drug that contains insulin.
(d) "Participant" means a resident of Utah who:
(i) has a prescription or standing prescription for a qualified prescription;
(ii) does not receive health coverage under the program; and
(iii) enrolls in the discount program.
(e) "Prescription drug" means the same as that term is defined in Section 58-17b-102.
(f) "Qualified prescription" means a prescription drug, including insulin and epinephrine auto-injectors, that the program has determined:
(i) treats a serious, prevalent, and ongoing condition;
(ii) does not have a generic substitute;
(iii) qualifies for a substantial rebate; and
(iv) would not result in financial losses to the state risk pool if sold as part of the discount program.
(g) "Rebate" means the same as that term is defined in Section 31A-46-102.
(2) The program shall create a prescription discount program for a participant to purchase a qualified prescription at a discounted, post-rebate price.
(3) The program shall:
(a) provide a participant with a card or electronic document that identifies the participant as eligible for the discount on a qualified prescription;
(b) provide a participant with information about pharmacies that will honor the discount; and
(c) provide a participant with instructions to pursue a reimbursement of the purchase price from the participant's health insurer.
(4) The program may not retain any amount of a rebate for a qualified prescription except for an amount necessary to make the state risk pool whole for providing the qualified prescription to participants.

(5) For each drug added to the discount program, the program shall notify the Health and Human Services Interim Committee, providing:
(a) the name of the drug; and
(b) the primary condition the drug treats.

Amended by Chapter 267, 2023 General Session
Amended by Chapter 328, 2023 General Session

49-20-422 Coverage of pregnancy and childbirth services, including doula, direct- entry midwife, and birthing center services.

(1) As used in this section:
(a) "Doula" means an individual who:
(i) provides information and physical and emotional support:
(A) to a pregnant or postpartum individual; and
(B) related to the pregnant or postpartum individual's pregnancy; and
(ii) is certified by one or more organizations approved by the program.
(b) "Pregnancy and childbirth services" means services provided to a pregnant individual before, during, or shortly after childbirth:
(i) by a doula for the services described in Subsections (1)(a)(i) and (ii); and
(ii) at a birthing center that:
(A) is licensed under Title 26B, Chapter 2, Licensing and Certifications, or accredited by the Commission for the Accreditation of Birth Centers; and
(B) may include services by a direct-entry midwife licensed under Title 58, Chapter 77, Direct-Entry Midwife Act, if the direct-entry midwife is engaged in the practice of direct-entry midwifery, as defined in Section 58-77-102.
(c) "Qualified individual" means a covered individual who is:
(i) within the state employees' risk pool; and
(ii)
(A) is pregnant; or
(B) was pregnant within the past six months.
(2) For a plan year that begins on or after July 1, 2023, and before July 1, 2026, the program shall cover pregnancy and childbirth services to a qualified individual.
(3) The program may establish limits for coverage under Subsection (2), including limits based on:
(a) the type or number of services provided;
(b) a qualified individual's physical or emotional condition; and
(c) conditions for provider participation.
(4) The program shall report to the Health and Human Services Interim Committee on or before October 1 of each year regarding coverage provided under Subsection (2), including:
(a) covered providers;
(b) covered services;
(c) provider payment rates;
(d) covered-individual cost sharing;
(e) total provider payments and covered-individual cost sharing; and
(f) any indicators of whether pregnancy and childbirth services covered under Subsection (2) have:
(i) reduced pregnancy or postpartum coverage costs; or
(ii) improved pregnancy or postpartum care.

Enacted by Chapter 292, 2023 General Session