HB0214S01 compared with HB0214

~~{deleted text}~~ shows text that was in HB0214 but was deleted in HB0214S01.

inserted text shows text that was not in HB0214 but was inserted into HB0214S01.

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.

Representative Raymond P. Ward proposes the following substitute bill:

INSURANCE COVERAGE MODIFICATIONS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Raymond P. Ward

Senate Sponsor: _____

LONG TITLE

General Description:

This bill enacts provisions relating to certain health care benefits.

Highlighted Provisions:

This bill:

- requires the Department of Health to apply for a Medicaid waiver or state plan amendment to allow the program to provide coverage for in vitro fertilization and genetic testing for certain individuals;
- requires the Public Employees' Health Benefit Program to provide coverage for in vitro fertilization and genetic testing for certain individuals;
- ~~{creates requirements relating to cost sharing for certain drugs}~~requires certain insurers to study whether coverage of in vitro fertilization would result in cost savings to the insurer; and

- creates reporting requirements.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

63I-2-226, as last amended by Laws of Utah 2019, Chapters 262, 393, 405 and last amended by Coordination Clause, Laws of Utah 2019, Chapter 246

63I-2-249, as last amended by Laws of Utah 2018, Chapters 38 and 281

ENACTS:

26-18-420, Utah Code Annotated 1953

31A-22-653, Utah Code Annotated 1953

49-20-420, Utah Code Annotated 1953

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

Section 1. Section **26-18-420** is enacted to read:

26-18-420. 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

(~~{~~iv~~}~~v) sickle cell anemia.

(b) "Qualified enrollee" means an individual who:

(i) is enrolled in the Medicaid program;

(ii) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and

(iii) 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 individual.

(2) Before January 1, 2021, the department shall apply for a Medicaid waiver or a state plan amendment with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement the coverage described in Subsection (3).

(3) If the waiver described in Subsection (2) is approved, the Medicaid program shall provide coverage to a qualified enrollee for:

(a) in vitro fertilization services~~{ to prevent the child of the qualified enrollee from having the same qualified condition for which the qualified enrollee is a genetic carrier;}~~; and

(b) genetic testing of a qualified enrollee who receives in vitro fertilization services under Subsection (3)(a)~~{; and}~~.

~~{ (c) genetic testing of an embryo that results from the in vitro fertilization described in Subsection (3)(a).~~

~~}~~ (4) Before November 1, 2022, and before November 1 of every third year thereafter, the department shall:

(a) calculate the change in state spending attributable to the coverage under this section; and

(b) report the amount described in Subsection (4)(a) to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee.

Section 2. Section **31A-22-653** is enacted to read:

31A-22-653.~~{ Cost sharing requirements for certain medications}~~ Study of coverage for in vitro fertilization and genetic testing -- Reporting -- Coverage requirements.

(1) As used in this section:

(a) "~~{~~Generic equivalent" means a drug that:

~~(i) has an identical amount of the same active chemical ingredients in the same dosage form;~~

~~(ii) meets applicable standards of strength, quality, and purity according to the United States pharmacopeia or other nationally recognized compendium; and~~

~~(iii) if administered in the same amounts, will provide comparable therapeutic effects~~~~}~~Qualified condition" means the same as that term is defined in Section 49-20-420.

(b) "Qualified ~~{~~prescription drug" means a prescription drug that does not have:

~~(i) a generic equivalent;~~

~~(ii) a biosimilar equivalent; or~~

~~(iii) any other similar off-patent pharmaceutical that would provide equivalent therapeutic value.~~

~~(2) For}~~insurer" means an insurer that provides a health benefit plan ~~{that is entered into or renewed}~~described in Section 31A-22-600 to more than 25,000 enrollees in the state.

(c) "Qualified enrollee" means an enrollee of a qualified insurer 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 enrollee.

(2) (a) A qualified insurer shall submit the information described in this Subsection (2) to the department with the qualified insurer's rate filings required under Section 31A-2-201.1 for a plan year beginning:

(i) on or after January 1, ~~{2021, an insurer shall include any amount paid by or on behalf of an enrollee}~~2022, but before December 31, 2022; and

(ii) on or after January 1, 2025, but before December 31, 2025.

(b) A qualified insurer shall study whether providing the coverage for the services described in Subsections (3)(a) through (c) for qualified enrollees will result in cost savings for the qualified insurer.

(c) (i) If a qualified insurer determines that providing the coverage described in Subsection (3) for qualified enrollees will result in cost savings for the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b), and:

(A) describe how the qualified insurer intends to provide the coverage described in Subsection (3); or

(B) submit an explanation of why the insurer will not provide the coverage described in Subsection (3).

(ii) If a qualified insurer determines that providing the coverage described in Subsection (3) will not result in cost savings to the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b).

(3) A qualified insurer shall consider coverage for:

(a) in vitro fertilization services for a qualified ~~{prescription drug toward the enrollee's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost sharing requirement}~~enrollee; and

(b) genetic testing of a qualified enrollee who received in vitro fertilization services under Subsection (3)(a).

(4) The department shall report the information received under Subsection (2) to the Health and Human Services Interim Committee on or before:

(a) for information submitted under Subsection (2)(a)(i), November 1, 2022; and

(b) for information submitted under Subsection (2)(a)(ii), November 1, 2025.

Section 3. Section **49-20-420** is enacted to read:

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

(~~{iv}~~v) sickle cell anemia.

(b) "Qualified ~~{enrollee}~~individual" means ~~{an}~~a covered individual who:

~~{ (i) is enrolled in the Medicaid program;~~

~~}~~ (~~{ii}~~i) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and

(~~{iii}~~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 ~~{enrollee}~~individual for:

(a) in vitro fertilization services~~{ to prevent the child of the qualified enrollee from having the same qualified condition for which the qualified enrollee is a genetic carrier;}~~; and

(b) genetic testing of a qualified ~~{enrollee}~~individual who receives in vitro fertilization services under Subsection (2)(a)~~{; and}~~.

~~{ (c) genetic testing of an embryo that results from the in vitro fertilization described in 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.

Section 4. Section **63I-2-226** is amended to read:

63I-2-226. Repeal dates -- Title 26.

(1) Subsection 26-7-8(3) is repealed January 1, 2027.

(2) Section 26-8a-107 is repealed July 1, 2024.

(3) Subsection 26-8a-203(3)(a)(i) is repealed January 1, 2023.

[~~(4) Subsection 26-18-2.3(5) is repealed January 1, 2020.~~]

[~~(5)~~] (4) Subsection 26-18-2.4(3)(e) is repealed January 1, 2023.

[~~(6)~~] (5) Subsection 26-18-411(8), related to reporting on the health coverage improvement program, is repealed January 1, 2023.

(6) Subsection ~~{~~26-18-419~~}~~26-18-420(4), ~~{regarding a requirement to report to the Legislature, is repealed January}~~related to reporting on coverage for in vitro fertilization and genetic testing, is repealed July 1, 2030.

[~~(7) Subsection 26-18-604(2) is repealed January 1, 2020.~~]

[~~(8)~~] (7) Subsection 26-21-28(2)(b) is repealed January 1, 2021.

[~~(9)~~] (8) Subsection 26-33a-106.1(2)(a) is repealed January 1, 2023.

[~~(10) Subsection 26-33a-106.5(6)(c)(iii) is repealed January 1, 2020.~~]

[~~(11)~~] (9) Title 26, Chapter 46, Utah Health Care Workforce Financial Assistance Program, is repealed July 1, 2027.

[~~(12) Subsection 26-50-202(7)(b) is repealed January 1, 2020.~~]

[~~(13) Subsections 26-54-103(6)(d)(ii) and (iii) are repealed January 1, 2020.~~]

[~~(14)~~] (10) Subsection 26-55-107(8) is repealed January 1, 2021.

[~~(15) Subsection 26-56-103(9)(d) is repealed January 1, 2020.~~]

[~~(16) Title 26, Chapter 59, Telehealth Pilot Program, is repealed January 1, 2020.~~]

[~~(17)~~] (11) Subsection 26-61-202(4)(b) is repealed January 1, 2022.

[~~(18)~~] (12) Subsection 26-61-202(5) is repealed January 1, 2022.

Section 5. Section **63I-2-249** is amended to read:

63I-2-249. Repeal dates -- Title 49.

(1) Section 49-20-106 is repealed January 1, 2021.

(2) Subsection 49-20-417(5)(b) is repealed January 1, 2020.

(3) Subsection ~~{49-20-419}~~49-20-420(3), regarding a requirement to report to the Legislature, is repealed January 1, 2030.