SB0139S01 compared with SB0139

~~{deleted text}~~ shows text that was in SB0139 but was deleted in SB0139S01.

inserted text shows text that was not in SB0139 but was inserted into SB0139S01.

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.

Senator Evan J. Vickers proposes the following substitute bill:

PRESCRIPTION COST AMENDMENTS

2022 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Evan J. Vickers

House Sponsor: _____

LONG TITLE

General Description:

This bill ~~{amends the Insurance Code}~~enacts provisions relating to cost sharing for certain prescription drugs.

Highlighted Provisions:

This bill:

~~{~~

- ~~defines terms;~~

~~}~~

- prohibits a health benefit plan from excluding payments made on behalf of an insured when determining whether the insured has satisfied the plan's cost sharing requirements~~{; and}~~.

~~{~~

- ~~requires a health benefit plan to apply certain payments by an insured for prescription drugs to the insured's deductible and maximum out-of-pocket limit.~~

~~}~~**Money Appropriated in this Bill:**

None

Other Special Clauses:

None

Utah Code Sections Affected:

ENACTS:

31A-22-657, Utah Code Annotated 1953

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

Section 1. Section **31A-22-657** is enacted to read:

31A-22-657.~~{ Cost sharing -- Payments}~~ Application of certain payments made on behalf of an insured ~~{-- Payments for certain drugs not paid for by the insurer}~~to cost sharing requirements.

(1) As used in this section:

(a) (i) "Cost sharing requirement" means copayments, coinsurance, deductibles, and other requirements for payment an insured is required to make under the provisions of a health benefit plan.

(ii) "Cost sharing requirement" does not include premiums.

(b) "Generic equivalent" means a drug product that is designated in the Approved Drug Products with Therapeutic Equivalence Evaluations prepared by the Center for Drug Evaluation and Research of the United States Food and Drug Administration as:

(i) the therapeutic equivalent of another drug product; and

(ii) an "A" rated drug product.

(c) "Manufacturer" means the same as that term is defined in Section 31A-48-102.

(d) "Qualified prescription drug" means a prescription drug, as defined in Section 58-17b-102, that is covered by the insurer under the insured's health benefit plan and for which:

(i) there is no generic equivalent~~{; or~~

~~(ii) a}~~ or interchangeable biological product, as defined in Section 58-17b-605.5;

(ii) there is no covered drug in the same therapeutic class used to treat the insured's condition that is preferred under a formulary for the insured's health benefit plan; or

(iii) if applicable to the prescription drug under the insured's health benefit plan, the insured has:

(A) received preauthorization from the health benefit plan for the prescription drug in accordance with Section 31A-22-650;

(B) completed the health benefit plan's step therapy protocol or other utilization management requirement for the prescription drug; or

(C) received authorization for ~~{payment}~~the prescription drug as the result of an internal or independent review in accordance with Section 31A-22-629.

(2) ~~{(a) Except as provided in Subsection (2)(b)}~~ For a plan entered into or renewed on or after January 1, 2023, when determining whether an insured has satisfied a health benefit plan's cost sharing requirement, the health benefit plan may not exclude payments made on behalf of the insured for a qualified prescription drug.

(~~{b}~~3) ~~{If}~~Notwithstanding Subsection (2), if application of Subsection (2~~{)(a}~~) would result in health savings account ineligibility under 26 U.S.C. Sec. 223, payments made on behalf of an insured for a qualified prescription drug that is not preventive care under 26 U.S.C. Sec. 223(c)(2)(C) shall apply to the insured's health savings account-qualified high deductible health plan ~~{deductible}~~cost sharing requirement only after the insured has satisfied the ~~{minimum deductible under 26 U.S.C. Sec. 223.~~

~~(3) (a) When determining whether an insured has satisfied a health benefit plan's deductible or maximum out-of-pocket limit, the health benefit plan shall, upon request by the insured, include payments made by the insured for a qualified prescription drug which was:~~

~~(i) eligible for payment by the health benefit plan; and~~

~~(ii) not paid for by the health benefit plan.~~

~~(b) An insurer that offers a health benefit plan shall provide an insured with a method for:~~

~~(i) making the request permitted under Subsection (3)(a); and~~

~~(ii) reporting and documenting to the insurer's satisfaction payments made by the insured for a qualified prescription drug described under Subsection (3)(a).~~

~~}~~health benefit plan's deductible.