1 # HEALTH INSURANCE - MEDICAL
2 # COMPLICATION EXCLUSIONS

3 2008 GENERAL SESSION
4 STATE OF UTAH

5 **Chief Sponsor: Peter C. Knudson**
6 House Sponsor: Bradley G. Last

7

8 **LONG TITLE**

9 **General Description:**

10 This bill amends the Insurance Code to require a health insurer to provide notice to an
11 enrollee of the exclusion from coverage of a secondary medical condition resulting from
12 an excluded condition or procedure.

13 **Highlighted Provisions:**

14 This bill:

15 ▸ applies to health insurers in the state and to the Public Employee's Health Program;
16 ▸ requires health insurers to report to the Legislature's Health and Human Services
17 Interim Committee by December 1, 2008 concerning efforts to inform enrollees of
18 exclusions or limitations of coverage for secondary medical conditions;
19 ▸ requires the Insurance Department to help develop examples of exclusions or
20 limitations of coverage for secondary medical conditions; and
21 ▸ beginning July 1, 2009, requires health insurers to give notice to enrollees that
22 coverage may be denied for secondary conditions resulting from a procedure, drug,
23 or condition that is excluded from coverage.

24 **Monies Appropriated in this Bill:**

25 None

26 **Other Special Clauses:**

27 None

28 **Utah Code Sections Affected:**

29 AMENDS:

30 **31A-22-605.5**, as last amended by Laws of Utah 2003, Chapter 8
31 **31A-22-613.5**, as last amended by Laws of Utah 2007, Chapter 307
32 **31A-22-723**, as last amended by Laws of Utah 2005, Chapter 78
33

34 *Be it enacted by the Legislature of the state of Utah:*
35 Section 1. Section **31A-22-605.5** is amended to read:
36 **31A-22-605.5. Application.**
37 (1) For purposes of this section "insurance mandate":
38 (a) means a mandatory obligation with respect to coverage, benefits, or the number or
39 types of providers imposed on policies of accident and health insurance; and
40 (b) does not mean an administrative rule imposing a mandatory obligation with respect
41 to coverage, benefits, or providers unless that mandatory obligation was specifically imposed on
42 policies of accident and health insurance by statute.
43 (2) (a) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), [~~any law~~
44 ~~imposed under this title that becomes effective after January 1, 2002, which provides for an~~
45 ~~insurance mandate for policies of accident and health insurance shall also~~] the following shall
46 apply to health coverage offered to the state employees' risk pool under Subsection
47 49-20-202(1)(a)[~~.~~]:
48 (i) any law imposed under this title that becomes effective after January 1, 2002, which
49 provides for an insurance mandate for policies of accident and health insurance; and
50 (ii) in accordance with Section 31A-22-613.5, disclosure requirements for coverage
51 limitations.
52 (b) If health coverage offered to the state employees' risk pool under Subsection
53 49-20-202(1)(a) offers coverage in the same manner and to the same extent as the coverage
54 required by the insurance mandate imposed under this title or coverage that is greater than the
55 insurance mandate imposed under this title, the coverage offered to state employees under
56 Subsection 49-20-202(1)(a) will be considered in compliance with the insurance mandate.
57 (c) The program regulated under Subsection 49-20-202(1)(a) shall report to the

58 Retirement and Independent Entities Committee created under Section [~~63E-1-102~~] 63E-1-201
59 by November 30 of each year in which a mandate is imposed under the provisions of this
60 section. The report shall include the costs and benefits of the particular mandatory obligation.
61 Section 2. Section **31A-22-613.5** is amended to read:
62 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**
63 **Care Plan.**
64 (1) [~~This~~] (a) Except as provided in Subsection (1)(b), this section applies [~~generally~~]
65 to all health insurance policies and health maintenance organization contracts.
66 (b) Subsection (3) applies to:
67 (i) all health insurance policies and health maintenance organization contracts; and
68 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
69 (2) The commissioner shall adopt a Basic Health Care Plan consistent with this section
70 to be offered under the open enrollment provisions of Chapter 30, Individual, Small Employer,
71 and Group Health Insurance Act.
72 (3) (a) The commissioner shall promote informed consumer behavior and responsible
73 health insurance and health plans by requiring an insurer issuing health insurance policies or
74 health maintenance organization contracts to provide to all enrollees, prior to enrollment in the
75 health benefit plan or health insurance policy, written disclosure of:
76 (i) restrictions or limitations on prescription drugs and biologics including the use of a
77 formulary and generic substitution; [~~and~~]
78 (ii) coverage limits under the plan[~~.~~]; and
79 (iii) any limitation or exclusion of coverage including:
80 (A) a limitation or exclusion for a secondary medical condition related to a limitation or
81 exclusion from coverage; and
82 (B) beginning July 1, 2009, easily understood examples of a limitation or exclusion of
83 coverage for a secondary medical condition.
84 (b) In addition to the requirements of Subsections (3)(a) [~~and~~], (d), and (e) an insurer
85 described in Subsection (3)(a) shall [~~submit~~] file the written disclosure required by this

86 Subsection (3) to the commissioner:
87 (i) upon commencement of operations in the state; and
88 (ii) anytime the insurer amends any of the following described in Subsection (3)(a):
89 (A) treatment policies;
90 (B) practice standards;
91 (C) restrictions; [or]
92 (D) coverage limits of the insurer's health benefit plan or health insurance policy[.]; or
93 (E) limitations or exclusions of coverage including a limitation or exclusion for a
94 secondary medical condition related to a limitation or exclusion of the insurer's health insurance
95 plan.
96 (c) The commissioner may adopt rules to implement the disclosure requirements of this
97 Subsection (3), taking into account:
98 (i) business confidentiality of the insurer;
99 (ii) definitions of terms; [and]
100 (iii) the method of disclosure to enrollees[.]; and
101 (iv) limitations and exclusions.
102 (d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available to
103 prospective enrollees and maintain evidence of the fact of the disclosure of:
104 (i) the drugs included;
105 (ii) the patented drugs not included; [and]
106 (iii) any conditions that exist as a precedent to coverage[.]; and
107 (iv) any exclusion from coverage for secondary medical conditions that may result from
108 the use of an excluded drug.
109 (e) Before December 1, 2008, insurers subject to this Subsection (3) shall report to the
110 Legislature's Health and Human Services Interim Committee and Business and Labor Interim
111 Committee, either collectively or independently regarding insurer efforts to inform enrollees of
112 any limitation of coverage or exclusion for a secondary medical condition when an enrollee, or
113 someone on the enrollee's behalf, contacts the insurer for pre-authorization of a procedure or

114 use of a drug that is excluded or limited from coverage.
115 (f) (i) The department shall develop examples of limitations or exclusions of a
116 secondary medical condition that an insurer may use under Subsection (3)(a)(iii).
117 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
118 (3)(a)(iii) or otherwise are for illustrative purposes only, and the failure of a particular fact
119 situation to fall within the description of an example does not, by itself, support a finding of
120 coverage.
121 (4) The Basic Health Care Plan adopted by the commissioner under this section shall
122 provide for:
123 (a) a lifetime maximum benefit per person not to exceed $1,000,000;
124 (b) an annual maximum benefit per person not to exceed $300,000;
125 (c) an out-of-pocket maximum per person not to exceed $5,000, including the
126 deductible;
127 (d) in relation to its cost-sharing features:
128 (i) a deductible of not less than $1,500 for major medical expenses; and
129 (ii) (A) a copayment of not less than:
130 (I) $25 per visit for office services; and
131 (II) $150 per visit to an emergency room; or
132 (B) coinsurance of not less than:
133 (I) 20% per visit for office services; and
134 (II) 20% per visit for an emergency room; and
135 (e) in relation to cost-sharing features for prescription drugs:
136 (i) a deductible of not less than $500; and
137 (ii) (A) a copayment of not less than:
138 (I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for
139 prescription drugs;
140 (II) the lesser of the cost of the prescription drug or $30 for the second level of cost for
141 prescription drugs; and

142 (III) the lesser of the cost of the prescription drug or $60 for the highest level of cost
143 for prescription drugs; or
144 (B) coinsurance of not less than:
145 (I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for
146 prescription drugs;
147 (II) the lesser of the cost of the prescription drug or 40% for the second level of cost
148 for prescription drugs; and
149 (III) the lesser of the cost of the prescription drug or 60% for the highest level of cost
150 for prescription drugs.
151 Section 3. Section **31A-22-723** is amended to read:
152 **31A-22-723. Group and blanket conversion coverage.**
153 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection
154 (3), all policies of accident and health insurance offered on a group basis under this title, or Title
155 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that a
156 person whose insurance under the group policy has been terminated is entitled to choose a
157 converted individual policy of similar accident and health insurance.
158 (2) A person who has lost group coverage may elect conversion coverage with the
159 insurer that provided prior group coverage if the person:
160 (a) has been continuously covered for a period of six months by the group policy or the
161 group's preceding policies immediately prior to termination;
162 (b) has exhausted either Utah mini-COBRA coverage as required in Section
163 31A-22-722 or federal COBRA coverage;
164 (c) has not acquired or is not covered under any other group coverage that covers all
165 preexisting conditions, including maternity, if the coverage exists; and
166 (d) resides in the insurer's service area.
167 (3) This section does not apply if the person's prior group coverage:
168 (a) is a stand alone policy that only provides one of the following:
169 (i) catastrophic benefits;

170 (ii) aggregate stop loss benefits;
171 (iii) specific stop loss benefits;
172 (iv) benefits for specific diseases;
173 (v) accidental injuries only;
174 (vi) dental; or
175 (vii) vision;
176 (b) is an income replacement policy;
177 (c) was terminated because the insured:
178 (i) failed to pay any required individual contribution;
179 (ii) performed an act or practice that constitutes fraud in connection with the coverage;
180 or
181 (iii) made intentional misrepresentation of material fact under the terms of coverage; or
182 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or
183 31A-30-107(2)(a).
184 (4) (a) The employer shall provide written notification of the right to an individual
185 conversion policy within 30 days of the insured's termination of coverage to:
186 (i) the terminated insured;
187 (ii) the ex-spouse; or
188 (iii) in the case of the death of the insured:
189 (A) the surviving spouse; and
190 (B) the guardian of any dependents, if different from a surviving spouse.
191 (b) The notification required by Subsection (4)(a) shall:
192 (i) be sent by first class mail;
193 (ii) contain the name, address, and telephone number of the insurer that will provide the
194 conversion coverage; and
195 (iii) be sent to the insured's last-known address as shown on the records of the employer
196 of:
197 (A) the insured;

198 (B) the ex-spouse; and
199 (C) if the policy terminates by reason of the death of the insured to:
200 (I) the surviving spouse; and
201 (II) the guardian of any dependents, if different from a surviving spouse.
202 (5) (a) An insurer is not required to issue a converted policy which provides benefits in
203 excess of those provided under the group policy from which conversion is made.
204 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health
205 benefit plan, the employee or member must be offered at least the basic benefit plan as provided
206 in [~~Subsection~~] Section 31A-22-613.5[~~(2)(a)~~].
207 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels
208 provided under the group policy, the conversion policy may offer benefits which are
209 substantially similar to those provided under the group policy.
210 (6) Written application for the converted policy shall be made and the first premium
211 paid to the insurer no later than 60 days after termination of the group accident and health
212 insurance.
213 (7) The converted policy shall be issued without evidence of insurability.
214 (8) (a) The initial premium for the converted policy for the first 12 months and
215 subsequent renewal premiums shall be determined in accordance with premium rates applicable
216 to age, class of risk of the person, and the type and amount of insurance provided.
217 (b) The initial premium for the first 12 months may not be raised based on pregnancy of
218 a covered insured.
219 (c) The premium for converted policies shall be payable monthly or quarterly as
220 required by the insurer for the policy form and plan selected, unless another mode or premium
221 payment is mutually agreed upon.
222 (9) The converted policy becomes effective at the time the insurance under the group
223 policy terminates.
224 (10) (a) A newly issued converted policy covers the employee or the member and must
225 also cover all dependents covered by the group policy at the date of termination of the group

226 coverage.

227 (b) The only dependents that may be added after the policy has been issued are children
228 and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

229 (c) At the option of the insurer, a separate converted policy may be issued to cover any
230 dependent.

231 (11) (a) To the extent the group policy provided maternity benefits, the conversion
232 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group
233 policy or the conversion policy until termination of a pregnancy that exists on the date of
234 conversion if one of the following is pregnant on the date of the conversion:

235 (i) the insured;

236 (ii) a spouse of the insured; or

237 (iii) a dependent of the insured.

238 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs
239 after the date of conversion.

240 (12) Except as provided in this Subsection (12), a converted policy is renewable with
241 respect to all individuals or dependents at the option of the insured. An insured may be
242 terminated from a converted policy for the following reasons:

243 (a) a dependent is no longer eligible under the policy;

244 (b) for a network plan, if the individual no longer lives, resides, or works in:

245 (i) the insured's service area; or

246 (ii) the area for which the covered carrier is authorized to do business; [~~or~~]

247 (c) the individual fails to pay premiums or contributions in accordance with the terms of
248 the converted policy, including any timeliness requirements;

249 (d) the individual performs an act or practice that constitutes fraud in connection with
250 the coverage;

251 (e) the individual makes an intentional misrepresentation of material fact under the
252 terms of the coverage; or

253 (f) coverage is terminated uniformly without regard to any health status-related factor

254 relating to any covered individual.

255 (13) Conditions pertaining to health may not be used as a basis for classification under

256 this section.