

# UTAH HEALTH REFORM: 2011 LEGISLATIVE UPDATE

a Summary of Selected Statutory Changes  
Enacted by Legislation Passed During  
the 2011 Annual General Session  
of the Utah Legislature

Prepared for the Health System Reform Task Force  
by the Office of Legislative Research and General Counsel

May 18, 2011



# Health Reform Legislation Enacted in 2011

## I. Utah Health Exchange

HB 128 Health Reform Amendments

## II. Medicaid/CHIP

HB 77 Medical Assistance Accountability

HB 84 Office of Inspector General of Medicaid Services

HB 174 Contracting for Medicaid Eligibility Determination Services

HB 211 Community Service Medicaid Pilot Program

HB 256 Children's Health Insurance and Medicaid Administrative Simplification

SB 180 Medicaid Reform

## III. PEHP

HB 18 Health Reform - Cost Containment

HB 404 State Health Insurance Amendments

HJR 46 Joint Resolution on State Health Insurance

# Health Reform Legislation Enacted in 2011

## IV. Health System Reform Task Force

HB 128 Health Reform Amendments

## V. Miscellaneous

HB 20 Amendments to Health Insurance Coverage in State Contracts

HB 128 Health Reform Amendments

HJR 38 Joint Resolution to Amend Rule of Evidence

SB 150 Negligent Credentialing

# I. Utah Health Exchange

## ■ Availability of Comparative Data

### **CONTRACTS FOR ENROLLMENT AND PLAN COMPARISON**

Requires the Exchange to contract with one or more private vendors for administration of the enrollment process on the Exchange, including establishing a mechanism for consumers to compare features of plans on the Exchange and to filter plans based on consumer preferences.

### **FACILITY REPORTS**

Requires the Department of Health's health care facility reports on charges, quality, and safety to be made available on the Utah Health Exchange.

### **LINKS TO INSURER WEBSITES—REPEALED**

Replaces a requirement that the Exchange provide access to private and government health insurance websites and their electronic application forms and submission procedures with a requirement that the Exchange provide information to consumers about private and public health programs for which they may qualify.

# I. Utah Health Exchange

## ■ Producers

### **RISK FACTORS TO PRODUCERS AND EMPLOYERS**

Requires the Utah Health Exchange to provide an employer, and the employer's insurance producer, with the employer group's risk factor used to calculate premiums for the group at the time Exchange plans are initially offered and at renewal.

### **CLARIFICATION OF PRODUCER/CARRIER RELATIONSHIP IN DCAM**

Clarifies that a producer designated by the Insurance Department as an appointed agent for the defined contribution arrangement market in the Utah Health Exchange may sell any product listed in the Exchange, and requires a carrier to appoint the producer to sell its products in the DCAM if the producer meets specified requirements.

### **LISTING OF PRODUCERS**

Requires the Office of Consumer Health Services to list all producers appointed for the Exchange, not just those appointed for the defined contribution arrangement market portion of the Exchange.

# I. Utah Health Exchange

- 2013 Provisions Repealed

**RISK ADJUSTING SMALL GROUPS OUTSIDE THE DCAM—REPEALED**

Repeals the Utah Statewide Risk Adjuster Act, which would have been effective January 1, 2013, and would have extended risk adjustment beyond small and large group plans marketed in the defined contribution arrangement market (DCAM) portion of the Exchange to also include other small group plans marketed inside the Exchange and small group plans marketed outside the Exchange.

**ALL NEW PLANS TO BE OFFERED IN EXCHANGE—REPEALED**

Repeals the provision effective January 1, 2013 that would have required a carrier to offer in the Utah Health Exchange any plan into which it was enrolling a new small employer group.

# I. Utah Health Exchange

## ■ Miscellaneous Provisions

### **LARGE GROUP DCAM PARTICIPATION—REPEALED**

Repeals the requirement that insurers participating in the defined contribution arrangement market portion of the Exchange offer defined contribution arrangement coverage to large employer groups on a pilot basis beginning January 1, 2011, and to all large employer groups beginning January 1, 2012. Repeals all other provisions related to participation in the defined contribution arrangement market by large groups.

### **ACTUARY REVIEW TRANSFERRED TO INSURANCE DEPARTMENT**

Transfers responsibility for the actuarial review of rating and underwriting practices of small employer group insurance plans inside and outside the Utah Health Exchange from the Utah Statewide Risk Adjuster Board to the Insurance Department. Also transfers the authority to impose a fee to fund the review from the Risk Adjuster Board to the Department. Creates a Health Insurance Actuarial Review Restricted Account to handle funds received and used to pay for the actuarial review.

# I. Utah Health Exchange

## ■ Miscellaneous Provisions

### **CALL CENTER**

Specifies the duties of the call center. Prohibits the call center from selling, soliciting, or negotiating a health plan on the Exchange. Beginning July 1, 2011, prohibits the call center from receiving producer compensation through the Exchange or being designated as the default producer for an employer group that enters the Exchange without a producer. Requires the Office of Consumer Health Services to establish a call center by contracting with one or more private vendors.

### **FEEES FOR CALL CENTER AND PLAN COMPARISON**

Expands the authorized purposes for which the Exchange may impose a fee to include funding of a call center and funding of a plan filtering and comparison mechanism based on consumer preferences.

### **ITEMIZATION OF EMPLOYER FEES**

Requires the Exchange to separately itemize for employers any fees it charges.

# I. Utah Health Exchange

- Miscellaneous Provisions

**RISK ADJUSTER BOARD MEMBERSHIP EXPANDED**

Expands the Utah Statewide Risk Adjuster Board Advisory Board to include one employer representative and up to two additional insurer representatives who represent an employer and insurers, respectively, that participate in the defined contribution arrangement portion of the Exchange.

**PREMIUM REGULATION PROHIBITED**

Prohibits the Utah Health Exchange from regulating premiums charged in the Exchange.

# I. Utah Health Exchange

## Plan Offering Requirements in DCAM Portion of Exchange

	TYPE	COVERAGE	DEDUCTIBLE	OUT OF POCKET MAXIMUM	2011 CHANGE
Required	HDHP 1 (Lowest Deductible)	One Family	1,200–1,450 2,400–2,650	1,200–4,350 2,400–7,950	
Required	HDHP 2 (Medium Deductible)	One Family	2,250–2,750 4,750–5,250	≤ 5,950 ≤ 11,900	Range around \$2,500/\$5,000 deductibles increased from ±\$0 to ±\$250
Required	HDHP 3 (Highest Deductible)	One Family	4,950–5,950 10,900–11,900	≤ 4,950–5,950 ≤ 10,900–11,900	Range around \$5,950/\$11,900 deductibles increased from -\$250 to -\$1,000
Required	Not specified	Actuarial value at least equal to 115% HDHP 1			Repealed
Required Required Required Required Required	Plan 1 Plan 2 Plan 3 Plan 4 Plan 5	The four most commonly selected plans open to new group enrollment that include, a provider panel, a deductible, copays, coinsurance, and pharmacy benefits			Reduced from five to four and insurance commissioner required to set standard for "most commonly selected"
Required	Alternative Conversion (NetCare, Low)	One Two Family	2,000 4,000 6,000	5,000 10,000 15,000	Not previously required in DCAM
Required	Alternative COBRA/mini-COBRA (NetCare, Low)	One Two Family	2,000 4,000 6,000	5,000 10,000 15,000	Not previously required in DCAM
Required	Alternative COBRA/mini-COBRA (NetCare, High)	One Two Family	4,000 8,000 12,000	10,000 20,000 30,000	Not previously required in DCAM
Optional	Not specified	Actuarial value greater than HDHP 1 (may offer unlimited number of plans)			Repealed
Optional	Not specified	Actuarial value greater than or equal to HDHP 3 (may offer unlimited number of plans)			Threshold changed from HDHP 2 to HDHP 3

Note: Amounts for HDHP 1, HDHP 2, and HDHP 3 are calculated based on state statutory requirements and 2011 federally-qualified HDHP provisions, which remain unchanged from 2010. Figures will change from year to year in response to federal adjustments for inflation. For HDHP 1 and HDHP 2, out of pocket maximums must be less than or equal to three times the respective deductible. OOP maximums exclude out-of-network services. HDHP 1, HDHP 2, and HDHP 3 must all be federally qualified HDHP plans. NetCare deductibles exclude certain expenses for well-child visits; preventive, primary, specialist, and urgent care; and supplemental accident coverage.

## II. Medicaid/CHIP

### ■ Cost Containment—Medicaid Reform Waiver

#### **PROVIDER AND CONSUMER INCENTIVES MODIFIED**

Requires the Department of Health to develop a Medicaid waiver proposal that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models. The proposal must:

- restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the proposal, maintain or improve recipient health status
- restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to:
  - maintain or improve their health status
  - use providers that deliver the most appropriate services at the lowest cost
  - identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that:
    - pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter
    - reward providers for delivering services that make the most positive contribution to a recipient's health status

## II. Medicaid/CHIP

- **Cost Containment—Medicaid Reform Waiver (continued)**

### **LIMITS FEE-FOR-SERVICE EXPENDITURES**

Limits total annual per-patient-per-month expenditures for services delivered through fee-for-service arrangements to total annual per-patient-per-month expenditures for services delivered through risk-based arrangements covering similar recipient populations and services.

### **LIMITS GENERAL FUND EXPENDITURES**

Limits the rate of growth in per-patient-per-month General Fund expenditures for Medicaid to the rate of growth in General Fund expenditures for all other programs (except when spending on other programs overall is being reduced).

### **SUBMISSION DEADLINE**

Requires the Department of Health to submit the proposed waiver to the Centers for Medicare and Medicaid Services by July 1, 2011.

## II. Medicaid/CHIP

- Growth Reduction and Stabilization Account

### **CREATION OF ACCOUNT**

Creates the Medicaid Growth Reduction and Budget Stabilization Restricted Account.

### **DEPOSITS INTO THE ACCOUNT**

If annual Medicaid growth is less than 8%, the difference (Medicaid growth savings) is deposited into the account by transferring General Fund revenue surplus (to the extent funds are available), and/or building a General Fund appropriation into the base budget of the next budget developed by the Legislature. Makes account deposits the first priority for any General Fund revenue surplus.

### **EXPENDITURES FROM THE ACCOUNT**

Restricts use of the account to funding Medicaid when annual Medicaid growth is estimated to be greater than 8%.

## II. Medicaid/CHIP

- **Fraud, Waste, and Abuse**

### **MEDICAID INSPECTOR GENERAL**

Creates an Office of Inspector General of Medicaid Services within the Governor's Office of Planning and Budget and transfers employees to the office from the Department of Health's Office of Internal Audit and Program Integrity. The inspector general is appointed by the governor with the advice and consent of the Senate for a term of two years and is required, among other duties, to identify and investigate fraud, waste, and abuse in Medicaid.

### **AUDIT INDEPENDENCE**

Places the Utah Office of Internal Audit and Program Integrity directly under the executive director of the Department of Health.

### **MANDATORY REPORTING**

Requires health care professionals, Medicaid providers, and state and local government officials and employees to report any Medicaid fraud, waste, or abuse of which they become aware and allows a reporter's identity to remain confidential upon request.

### **DIVISION OF HEALTH CARE FINANCING DUTIES**

Describes duties and reporting requirements for the Division of Health Care Financing relating to management and oversight of the state's Medicaid and medical assistance programs.

## II. Medicaid/CHIP

### ■ Fraud, Waste, and Abuse (continued)

#### **ANNUAL REPORTING OF IMPROPERLY USED FUNDS**

Requires the Division of Health Care Financing, beginning in 2012, to annually report to the Health and Human Services Interim Committee on incidents of improperly used or paid Medicaid funds and medical or hospital assistance funds, repayment of those funds, and the division's compliance with the recommendations made in the December 2010 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of Legislative Auditor General.

#### **PHARMACEUTICAL COST CONTROL**

Requires the Division of Health Care Financing to keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the pharmaceuticals that represent the highest 45% of state Medicaid expenditures for pharmaceuticals and on an annual basis for the remaining pharmaceuticals:

- tracking changes in the price of pharmaceuticals
- checking the availability and price of generic drugs
- reviewing and updating the state's maximum allowable cost list
- comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists

## II. Medicaid/CHIP

- Fraud, Waste, and Abuse (continued)

### **ADMINISTRATIVE PROCEEDINGS—REPORTING OF RESULTS**

Requires the presiding officer of an administrative proceeding of the Department of Health related to recovery of Medicaid funds to report directly to the department's executive director or, at the discretion of the executive director, to the director of the Office of Internal Audit and Program Integrity within the department.

### **ADMINISTRATIVE PROCEEDINGS—PARTICIPATION**

Specifies that the director of the Office of Internal Audit and Program Integrity, or the director's designee, and the Medicaid Inspector General, or the Inspector General's designee, may attend any Department of Health administrative proceeding related in any way to Medicaid or Medicaid funds.

## II. Medicaid/CHIP

- Eligibility Simplification and Privatization

**MEDICAID, PCN, UPP—SIMPLIFIED ENROLLMENT AND RENEWAL**

Requires the Department of Health to apply for grants to fund a simplified enrollment and renewal process for Medicaid, the Utah Premium Partnership, and the Primary Care Network that would allow an eligibility worker, with an applicant's consent, to obtain the applicant's adjusted gross income from the State Tax Commission. Also authorizes the department to enter into agreements with financial institutions to obtain applicant and enrollee asset information for purposes of verifying program eligibility. Requires simplified enrollment and renewal processes to be implemented by July 1, 2012, if funding is available.

**CHIP—SIMPLIFIED ENROLLMENT**

Requires the Children's Health Insurance Program to apply for grants to fund a simplified enrollment process that would allow an eligibility worker, with an applicant's consent, to obtain the applicant's adjusted gross income from the State Tax Commission. Requires CHIP to implement the process if funds are available. A similar requirement already exists for CHIP renewal.

## II. Medicaid/CHIP

- Eligibility Simplification and Privatization (continued)

### **ELIGIBILITY DETERMINATION**

Requires the Department of Health to work with the Department of Workforce Services, the Department of Human Services, and the Privatization Policy Board to study whether the state's eligibility determination systems for Medicaid, CHIP, and other programs for which the Department of Workforce Services administers eligibility determination, can be consolidated or privatized. Requires a report to the Health and Human Services Interim Committee prior to October 20, 2011, on the findings of the study, including advantages and disadvantages of privatization.

## II. Medicaid/CHIP

- Dental Benefits

### **CHIP—BENCHMARK PLAN TYPE AND EQUIVALENCY CHANGED**

Replaces the requirement that the Children's Health Insurance Program dental plan be actuarially equivalent to the commercial HMO plan with largest enrollment in the state with a requirement that the plan be equivalent (not actuarially equivalent) to the commercial dental benefit plan (not an HMO plan) with the largest non-Medicaid enrollment in the state.

### **MEDICAID DENTAL CONTRACT REQUIREMENTS**

Requires the Division of Health Care Financing to bid out Medicaid dental benefits in 2011 and at least once every five years thereafter, unless doing so would increase program costs. Contracts may be entered into with up to three bidders, which each must accept 100% of the risk for any difference between the division's premium payments per client and actual dental expenditures. Authorizes the division to bid out dental benefits separately from other program benefits.

## II. Medicaid/CHIP

- Community Service Waiver

### **COMMUNITY SERVICE PILOT PROGRAM**

Requires the Department of Health to apply by January 1, 2012, for a Medicaid waiver that would authorize the state to implement a Medicaid community service pilot program. The program would require as many as 99 Medicaid recipients capable of providing community services to others to perform a certain number of hours of community service as a condition of receiving Medicaid benefits.

# III. Public Employees Health Program

## ■ Cost Containment

### **UTILIZATION**

Requires a high deductible health plan/health savings account combination offered by the Utah State Retirement Office to promote appropriate utilization of health care, including preventive care.

### **CONSUMER EDUCATION**

Requires the Utah State Retirement Office to offer to all employees training, including online training, regarding health plans offered to them. Requires the State of Utah to require each of its employees to complete the training before the end of the 2011 open enrollment period.

### **AUTO-ENROLLMENT INTO HDHP/HSA**

Requires a state employee who is hired on or after July 1, 2011, and offered health insurance to be automatically enrolled in a high deductible health plan unless the employee elects otherwise during open enrollment.

### **ACTUARIAL NEUTRALITY—REPEALED**

Repeals the requirement that the Utah State Retirement Office administer a high deductible health plan/health savings account combination in a way that is actuarially neutral to an employer's overall health plan.

# III. Public Employees Health Program

## ■ Response to Legislative Audit

### **DECREASE TOTAL PREMIUMS 2%**

Directs PEHP to decrease the overall combined employer and employee premiums for coverage by 2% from FY 2010-11 premiums.

### **CHANGE PREMIUM SPLIT TO 90/10**

Directs PEHP and the Department of Human Resource Management to change the employer/employee shares of total premium for state employee HMO coverage to 90%/10% and to adjust the shares for high deductible health plan coverage proportionately.

### **NO INCREASE IN DENTAL**

Directs PEHP to not increase dental plans' combined employer and employee premiums above FY 2010-11.

### **ADJUST COSTS AND USE RESERVES**

Directs PEHP to, before July 2012, adjust its costs, but not reduce covered benefits, in a way that employer and employee premiums are sufficient to cover costs. Expresses the Legislature's intent that PEHP draw down its reserves as necessary to fund medical and dental plans.

# III. Public Employees Health Program

- Response to Legislative Audit (continued)

**PRESERVE GRANDFATHERED PLAN STATUS**

Directs PEHP to structure its fiscal year 2011-12 plans in a way that maintains their grandfathered plan status under the federal Affordable Care Act.

- Interim Study—Use of Exchange by State Employees

**COST CONTROL, EMPLOYEE HEALTH, AND PEHP COMPETENCIES**

Requires the Health System Reform Task Force to review and make recommendations on legislation necessary to implement the governance structure for the Health Insurance Exchange in a way that provides better control of state expenditures on health care for state employees, retirees, and their families, provides incentives to improve health among state employees, and makes better use of PEHP assets and competencies.

# III. Public Employees Health Program

- Interim Study—Quality, Consumerism, Cost Containment, Plan Offerings, Employer Contribution, Structure, Risk-Bearing Role

## **RETIREMENT AND INDEPENDENT ENTITIES INTERIM COMMITTEE STUDY**

Requires the Retirement and Independent Entities Interim Committee to make recommendations on the following issues:

- improvements to the way in which the state provides health insurance to employees, retirees, and their families
- methods to improve the quality of health care for employees, retirees, and their families
- methods to engage an employee as an informed consumer in the health care decisions made by the employee
- methods for the state to better control state expenditures on health care
- optimal use of the assets and competencies of the Public Employees' Benefit and Insurance Program, including:
  - the type of health insurance benefits offered by the state
  - the structure and type of contributions made by the state for employee health insurance benefits
  - the structure and risk bearing role of the Public Employees' Benefit Plan Program

# IV. Health System Reform Task Force

- Reauthorized Through December 30, 2011
- Review and Make Recommendations On:

## **RESPONDING TO FEDERAL REFORM, INCLUDING WHETHER TO DEVELOP AN AMERICAN HEALTH BENEFIT EXCHANGE**

### **LEGISLATION NECESSARY TO IMPLEMENT:**

- a governance structure for the Health Insurance Exchange that provides better control of state expenditures on health care for state employees, retirees, and their families, provides incentives to improve health among state employees, and makes better use of PEHP assets and competencies
- a blueprint for Health Insurance Exchange operations
- Health Insurance Exchange funding
- better use of PEHP assets and competencies

## IV. Health System Reform Task Force

- Review and Make Recommendations On: (continued)

**THE DIVISION OF INSURANCE MARKET REGULATORY FUNCTIONS  
ACROSS STATE AGENCIES**

**THE SMALL GROUP MARKET WITHIN THE DEFINED  
CONTRIBUTION ARRANGEMENT PORTION OF THE EXCHANGE**

**THE EXCHANGE RISK ADJUSTER**

**COST CONTAINMENT, INCLUDING PAYMENT AND DELIVERY  
DEMONSTRATION PROJECTS AND MEDICAL LIABILITY**

**BALANCING PLAN COSTS AND BENEFITS IN THE EXCHANGE,  
INCLUDING CONSIDERING WHETHER CERTAIN BENEFITS SHOULD  
BE COVERED**

# V. Miscellaneous

## ■ Rating/Underwriting/Application

### **GENDER ALLOWABLE AS CASE CHARACTERISTIC**

Allows an insurance carrier to use the gender of an employee or employee's spouse as a case characteristic for purposes of determining small group premium rates (in addition to the three characteristics already allowed—age, geography, and family composition).

### **TIMING OF RENEWAL RATES**

For plans that renew on or after March 1, 2012:

- requires carriers to provide renewal rates to small group employers, and their producers, at least 60 days prior to renewal
- requires the Utah Health Exchange to provide renewal rates to employer groups participating in the defined contribution arrangement market, and their producers, at least 60 days prior to renewal

### **NetCare RISK FACTOR LIMIT**

Prevents an insurer from using a risk factor greater than an employer's current risk factor when providing coverage to an employee who selects Utah NetCare as an alternative to either COBRA or mini-COBRA coverage.

# V. Miscellaneous

- Rating/Underwriting/Application (continued)

## **HEALTH HISTORY**

Shortens the period of time for which an individual or small group insurer may collect a health history from 10 years to five years.

## **UNIFORM APPLICATIONS**

Transfers authority for approving modifications to the uniform insurance application form from the Office of Consumer Health Services to the Insurance Commissioner and deletes the requirement that an insurer offering large group coverage in the Utah Health Exchange use uniform application and waiver of coverage forms.

# V. Miscellaneous

- Coverage Requirements

## **INSURANCE OFFERED BY STATE CONTRACTORS**

Amends the definition of "qualified health insurance coverage" that contractors with certain state or other government entities must offer their employees by increasing the individual deductible from \$750 to \$1,000 and the family deductible from \$2,250 to \$3,000 in the largest HMO plan benchmark option, and decreasing the minimum employer premium contribution from 75% to 60% in the high deductible health plan option.

## **MENTAL HEALTH COVERAGE**

Requires insurers to offer small employer groups mental health coverage required to be offered under federal law.

- Payment and Delivery Reform Demonstration Projects

## **CONVENER CHANGES**

Makes the facilitation of payment and delivery reform demonstration projects permissive rather than mandatory, moves convening and coordination roles from the Office of Consumer Health Services to the Department of Health, and eliminates the requirement that meetings of health care providers and payers be convened through a neutral, non-biased entity.

## V. Miscellaneous

### ■ Availability of Comparative Health Data

#### **CLINIC DATA AND ADDITIONAL MEASURES**

Requires the Department of Health, beginning July 1, 2012, to publish—in addition to existing reports on health care facility charges, quality, and safety—measures that compare the quality of care across hospitals and clinics for diabetes, heart disease, and other conditions, and for routine and preventive care. Requires the quality data to first be published in a statewide aggregated format, which does not compare individual facilities, no later than December 1, 2011. Requires at least five new measures to be added each year until July 1, 2015.

#### **EXEMPTION FROM ALL PAYER CLAIMS DATABASE**

Excludes health insurers with less than 2,500 enrollees from the provisions of the Utah Health Data Authority Act, including requirements to submit data used in the All Payer Claims Database.

#### **COMPARATIVE INFORMATION LIMITED**

Limits the number of plans for which an insurer must submit information for posting on the Exchange, including prompt payment rates, claims denial rates, and comparative information about specific plans, to only those plans that are posted in the Exchange (rather than all plans offered in the state).

# V. Miscellaneous

- Availability of Comparative Health Data (continued)

**HEALTH DATA COMMITTEE EXPANDED**

Expands Health Data Committee membership and requires that members be knowledgeable about the collection, the use, and, in some cases, the analysis of health care data.

- Customer Service Representatives

**SCOPE OF PRACTICE**

Prohibits a customer service representative from maintaining an office independent of the representative's licensed producer or consultant employer, and except for providing quotes, prohibits a representative from selling, soliciting, negotiating, or binding coverage.

- Federal Health Reform

**ENFORCEMENT**

Requires the Insurance Commissioner to enforce federal health reform provisions related to plan coverage, cost sharing, consumer information, premium rate review, and administration.

# V. Miscellaneous

- Medical Liability

**"I'm Sorry" PROTECTION AMENDED**

Amends Rule 409, Utah Rule of Evidence, regarding expressions of apology by health care professionals and employees.

**NEGLIGENT CREDENTIALING SUITS PROHIBITED**

Provides that negligent credentialing as a cause of action will not be recognized in a medical malpractice action.

# V. Miscellaneous

## ■ Changes to Basic Coverage (continued)

### STATUTES CITED BELOW ARE SHOWN ON NEXT PAGE

MINIMUM OFFERING REQUIREMENTS IN THE INDIVIDUAL AND SMALL GROUP MARKETS: IMPACT OF 2011 H.B. 128 (effective 5/10/11)  
(Other than minimum requirements for COBRA, mini-COBRA and conversion policies)

Carriers Must Offer				Definition of Basic Coverage				Applicable Cites			
				Type	Deductibles		Out of Pocket Maximum				
Effective	Basic Coverage	Coverage Greater Than or Equal to Basic Coverage	A NetCare plan		Individual	Family	Individual	Family	31A-30-103(4) (basic coverage definition)	31A-30-109 (basic coverage and NetCare offering requirements)	31A-22-613.5(3) (basic coverage description and offering requirement)
Before May 10, 2011	Yes	Yes	Yes	Federally Qualified HDHP	\$1,200-\$1,450	\$2,400-\$2,650	<=3x deductible (\$4,350 max.)	<=3x deductible (\$7,950 max.)	X	X	X
Beginning May 10, 2011	No	Yes	Yes	Federally Qualified HDHP	\$1,200	\$2,400	<=3x deductible (\$3,600 max.)	<=3x deductible (\$7,200 max.)	X	X	
Beginning January 1, 2012	No	Yes	Yes	A plan that is actuarially equivalent to the insurer's NetCare COBRA, mini-COBRA, or conversion plan with the highest actuarial value <sup>1</sup>			No limits		X	X	

<sup>1</sup>A carrier must offer at least two NetCare plans to satisfy mini-COBRA, requirements---a high deductible plan and a low deductible plan---and either a high deductible or low deductible NetCare plan to satisfy conversion requirements. A NetCare plan must meet the state-defined requirements of Utah Code Ann. Section 31A-22-724.

# V. Miscellaneous

## ■ Changes to Basic Coverage (continued)

### STATUTES BELOW ARE CITED ON PREVIOUS PAGE

Section 31A-30-103(4): (effective 5/10/11)

(4) "Basic benefit plan" or "basic coverage" means ~~[the coverage provided in the Basic Health Care Plan under Section 31A-22-613-5-]~~ a health benefit plan that:

- (a) until January 1, 2012:
  - (i) is a federally qualified high deductible health plan;
  - (ii) has a deductible that has the lowest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law; and
  - (iii) does not exceed an annual out-of-pocket maximum equal to three times the amount of the deductible; and
- (b) on or after January 1, 2012, is actuarially equivalent to the NetCare plan with the highest actuarial value, as provided in Section 31A-22-724.

Section 31A-22-613.5 (effective 5/10/11)

~~[(3) An insurer who offers a health benefit plan under Chapter 30, Individual, Small Employer, and Group Health Insurance Act, shall offer a basic health care plan subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:]~~

- ~~[(a) is a federally qualified high deductible health plan;]~~
- ~~[(b) has a deductible that is within \$250 of the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and]~~
- ~~[(c) does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible.]~~

Section 31A-30-109 (existing code)

(1) An individual carrier who offers individual coverage pursuant to Section 31A-30-108:

- (a) shall offer in the individual market under this chapter:
  - (i) a choice of coverage that is at least equal to or greater than basic coverage; and
  - (ii) beginning January 1, 2010, the Utah NetCare Plan described in Subsection 31A-22-724(2); and
- (b) may offer a choice of coverage that:
  - (i) costs less than or equal to the plan described in Subsection (1)(a)(ii); and
  - (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

(2) Beginning January 1, 2010, a small employer group carrier who offers small employer group coverage pursuant to Section 31A-30-108:

- (a) shall offer in the small employer group market under this part:
  - (i) a choice of coverage that is at least equal to or greater than basic coverage; and
  - (ii) coverage under the Utah NetCare Plan described in Section 31A-22-724; and
- (b) may offer in the small employer group market under this part, a choice of coverage that:
  - (i) costs less than or equal to the coverage in Subsection (2)(a); and
  - (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

(3) Nothing in this section limits the number of health benefit plans an insurer may offer.