MEDICAL EXCLUSIONS IN INDIVIDUAL HEALTH INSURANCE POLICIES

2000 GENERAL SESSION

STATE OF UTAH

Sponsor: Howard C. Nielson

AN ACT RELATING TO INSURANCE; PERMITTING AN INSURER AND AN INSURED TO AGREE TO EXCLUDE A SPECIFIC HEALTH CARE CONDITION FROM COVERAGE IN AN INDIVIDUAL HEALTH INSURANCE POLICY; CLARIFYING THAT FOR INSURANCE PURPOSES, AN EXCLUDED HEALTH CARE CONDITION IS AN UNCOVERED PREEXISTING CONDITION; AND PROVIDING AN EFFECTIVE DATE.

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-30-107, as last amended by Chapter 329, Laws of Utah 1998

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

Section 1. Section **31A-30-107** is amended to read:

31A-30-107. Renewal -- Limitations -- Exclusions.

(1) A health benefit plan subject to this chapter is renewable with respect to all covered individuals at the option of the covered insured except in any of the following cases:

(a) nonpayment of the required premiums;

(b) fraud or misrepresentation of the employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(c) noncompliance with the covered carrier's minimum participation requirements;

(d) noncompliance with the covered carrier's employer contribution requirements;

(e) repeated misuse of a provider network provision; or

(f) an election by the covered carrier to nonrenew all of its health benefit plans issued to covered insureds in this state, in which case the covered carrier shall:

(i) provide advanced notice of its decision under this subsection to the commissioner in each state in which it is licensed; and

(ii) provide notice of the decision not to renew coverage to all affected covered insureds

and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the covered carrier. Notice to the commissioner under this subsection shall be provided at least three working days prior to the notice to the affected covered insureds.

(2) A covered carrier that elects not to renew a health benefit plan under Subsection (1)(f) is prohibited from writing new business subject to this chapter in this state for a period of five years from the date of notice to the commissioner.

(3) When a covered carrier is doing business subject to this chapter in one service area of this state, Subsections (1) and (2) apply only to the covered carrier's operations in that service area.

(4) Health benefit plans covering covered insureds shall comply with the following provisions:

(a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's coverage due to a preexisting condition.

(ii) A health benefit plan may not define a preexisting condition more restrictively than:

(A) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding <u>enrollment date or</u> the effective date of coverage<u>, whichever comes first</u>; or

(B) for an individual insurance policy, a pregnancy existing on the effective date of coverage.

<u>(iii) An individual insurer shall offer a health benefit plan in compliance with Subsections (4)(a)(i) and (ii), and may, when the insurer and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes a specific physical condition consistent with Subsections (4)(a)(iv) and (v).</u>

<u>(iv) The commissioner shall establish, in rule, a list of nonlife threatening and nondegenerative physical conditions that may be the subject of a condition-specific exclusion rider.</u>

<u>(v) A condition-specific exclusion rider shall be limited to the excluded condition and may not extend to any secondary medical condition that may or may not be directly related to the excluded condition.</u>

(b) (i) A covered carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time the individual was previously covered by public or private health insurance or by any other health benefit arrangement that provided benefits with respect to such services, provided that:

(A) the previous coverage was continuous to a date not more than [~~62~~] 63 days prior to the effective date of the new coverage; and

(B) the insured provides notification of previous coverage to the covered carrier within 36 months of the coverage effective date if the insurer has previously requested such notification.

(ii) The period of continuous coverage under Subsection (4)(b)(i)(A) shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under such plan.

(iii) Credit for previous coverage as provided under Subsection (4)(b)(i)(A) need not be given for any condition which was previously excluded under a condition-specific exclusion rider. A new preexisting waiting period may be applied to any condition that was excluded by a rider under the terms of previous individual coverage.

Section 2. **Effective date.**

This act takes effect on July 1, 2000.