

Effective 1/1/2016

31A-22-613.5 Price and value comparisons of health insurance.

- (1)
 - (a) This section applies to all health benefit plans.
 - (b) Subsection (2) applies to:
 - (i) all health benefit plans; and
 - (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
- (2)
 - (a) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to:
 - (i) provide to all enrollees, prior to enrollment in the health benefit plan written disclosure of:
 - (A) restrictions or limitations on prescription drugs and biologics including:
 - (I) the use of a formulary;
 - (II) co-payments and deductibles for prescription drugs; and
 - (III) requirements for generic substitution;
 - (B) coverage limits under the plan;
 - (C) any limitation or exclusion of coverage including:
 - (I) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and
 - (II) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition; and
 - (D) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)
 - (ii) and the terms associated with the exchange of benefits; and
 - (ii) provide the commissioner with:
 - (A) the information described in Subsections 31A-22-635(5) through (7) in the standardized electronic format required by Subsection 63N-11-107(1); and
 - (B) information regarding insurer transparency in accordance with Subsection (4).
 - (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to the commissioner:
 - (i) upon commencement of operations in the state; and
 - (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
 - (A) treatment policies;
 - (B) practice standards;
 - (C) restrictions;
 - (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
 - (E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.
 - (c) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):
 - (i) either:
 - (A) in writing; or
 - (B) on the insurer's website; and
 - (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.
 - (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:
 - (i) the drugs included;

- (ii) the patented drugs not included;
 - (iii) any conditions that exist as a precedent to coverage; and
 - (iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.
- (e)
- (i) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).
 - (ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.
- (3) The commissioner:
- (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Section 63N-11-104; and
 - (b) may request information from an insurer to verify the information submitted by the insurer under this section.
- (4) The commissioner shall:
- (a) convene a group of insurers, a member representing the Public Employees' Benefit and Insurance Program, consumers, and an organization that provides multipayer and multiprovider quality assurance and data collection, to develop information for consumers to compare health insurers and health benefit plans on the Health Insurance Exchange, which shall include consideration of:
 - (i) the number and cost of an insurer's denied health claims;
 - (ii) the cost of denied claims that is transferred to providers;
 - (iii) the average out-of-pocket expenses incurred by participants in each health benefit plan that is offered by an insurer in the Health Insurance Exchange;
 - (iv) the relative efficiency and quality of claims administration and other administrative processes for each insurer offering plans in the Health Insurance Exchange; and
 - (v) consumer assessment of each insurer or health benefit plan;
 - (b) adopt an administrative rule that establishes:
 - (i) definition of terms;
 - (ii) the methodology for determining and comparing the insurer transparency information;
 - (iii) the data, and format of the data, that an insurer shall submit to the commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63N-11-107; and
 - (iv) the dates on which the insurer shall submit the data to the commissioner in order for the commissioner to transmit the data to the Health Insurance Exchange in accordance with Section 63N-11-107; and
 - (c) implement the rules adopted under Subsection (4)(b) in a manner that protects the business confidentiality of the insurer.

Amended by Chapter 257, 2015 General Session
Amended by Chapter 283, 2015 General Session