LEGISLATIVE GENERAL COUNSEL
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H.B. 347

PATIENT BILL OF RIGHTS

1999 GENERAL SESSION

STATE OF UTAH

Sponsor: Mary Carlson

AN ACT RELATING TO INSURANCE; CLARIFYING WHEN PREAUTHORIZATION FOR EMERGENCY MEDICAL CARE MAY BE REQUIRED; ESTABLISHING A PROCESS FOR STANDING REFERRALS TO A SPECIALIST AND INDEPENDENT EXTERNAL REVIEWS OF ADVERSE HEALTH CARE DECISIONS; ESTABLISHING A MINIMUM BENEFIT FOR PRESCRIPTION DRUGS THAT ARE EXCLUDED FROM AN INSURANCE COMPANY'S FORMULARY; AND PROVIDING AN EFFECTIVE DATE.

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

ENACTS:

31A-22-625, Utah Code Annotated 1953

31A-22-626, Utah Code Annotated 1953

31A-22-627, Utah Code Annotated 1953

31A-22-628, Utah Code Annotated 1953

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

Section 1. Section **31A-22-625** is enacted to read:

31A-22-625. Coverage of emergency medical services.

(1) A health insurance policy or health maintenance organization contract may not:

(a) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; or

(b) deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary to stabilize the emergency medical condition of an insured on the ground that preauthorization for the treatment was not obtained.

(2) (a) A health insurance policy or health maintenance organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's

condition has been stabilized.

(b) An insurer who does not accept or reject a request for authorization under Subsection (2)(a) within an hour of receiving the request may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section, "emergency medical condition" means any medical condition of a recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury was of such a nature that the failure to obtain immediate medical care could result in:

(a) placing the insured's health in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

Section 2. Section **31A-22-626** is enacted to read:

31A-22-626. Standing referral to a specialist.

(1) An insurer who does not allow direct access to a health care specialist shall establish and implement a procedure by which an insured may obtain a standing referral to a health care specialist.

(2) The procedure established under Subsection (1):

(a) shall provide for a standing referral to a specialist if the insured's primary care provider determines, in consultation with the specialist, that the insured needs continuing care from the specialist; and

(b) may require the approval of the insurer, in consultation with the insured, the primary care provider, and the specialist, of a treatment plan, which may include:

(i) a limit on the number of visits to the specialist;

(ii) a time limit on the duration of the referral; and

(iii) mandatory updates on the insured's condition.

Section 3. Section **31A-22-627** is enacted to read:

31A-22-627. Independent external review of health care service decisions.

(1) An insured who has exhausted all applicable internal review procedures under a health insurance policy or health maintenance organization contract may seek an independent external review of a decision of the insurer to deny, reduce, or terminate coverage or to deny payment for

a health care service if:

(a) the insured requests the external independent review in writing;

(b) the amount at issue exceeds $100; and

(c) the decision of the insurer is based on one of the following reasons:

(i) the treatment was not medically necessary;

(ii) the treatment was not provided by an appropriate health care provider;

(iii) the treatment was experimental, investigational, or involved an off-label drug; or

(iv) the treatment was for a preexisting condition.

(2) The department shall adopt rules necessary to carry out the purposes of this section and to ensure that:

(a) an independent external review be conducted:

(i) by a panel approved by the department that includes a health care provider and members without conflicts of interest;

(ii) in accordance with standards of decision-making based on objective clinical evidence; and

(iii) in a timely manner with special attention given to resolving decisions involving emergency or urgent health care services;

(b) an insured:

(i) is given adequate notice of review rights under this section;

(ii) is informed of the right to use outside assistance during the review process and to submit relevant evidence;

(iii) pays a processing fee of not more than $25; and

(iv) is protected against retaliation for exercising review rights under this section;

(c) a written decision of the panel is issued to both the insured and the insurer; and

(d) health care information is maintained in accordance with state and federal law.

(3) Except as provided in Subsection (2)(b)(iii), an insurer shall pay for the cost of an independent external review.

Section 4. Section **31A-22-628** is enacted to read:

31A-22-628. Minimum benefit coverage for nonformulary prescription drugs.

(1) This section applies generally to all health insurance policies and health maintenance organization contracts.

(2) Consistent with Subsection (3), an insurer who offers a prescription drug benefit may establish a formulary and may determine which prescription drugs to include on or exclude from the formulary.

(3) An insurer who establishes a formulary shall provide a minimum benefit for medically necessary, federal Food and Drug Administration-approved prescription drugs that are excluded from the formulary. The minimum benefit shall be no less than 75% of the amount the insurer would have to pay under the policy or contract for the most expensive comparable prescription drug, not to exceed the benefit amount the insurer would have to pay if the prescription drug were included on the formulary.

(4) An insurer shall pay a claim submitted under Subsection (3) within 20 days of receiving the necessary information to process the claim.

(5) An insurer shall include an explanation of this section in the written materials it is required to give an enrollee, prior to enrollment, on prescription drug coverage and limitations under Subsection 31A-22-613.5(9).

(6) The commissioner shall encourage and work with insurers to make formulary information available on the Internet.

(7) As used in this section:

(a) "comparable prescription drug" means a prescription drug that has the equivalent dosage and for which there is general consensus within the medical community that it treats the same medical condition as another prescription drug;

(b) "necessary information" may include the medical opinion of the insured's physician; and

(c) "pay" means a direct payment to a vendor of a nonformulary prescription drug or a direct reimbursement to an insured who purchased a nonformulary prescription drug.

Section 5. **Effective date.**

This act takes effect on July 1, 1999.

Legislative Review Note
as of 2-16-99 2:15 PM

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel