CATASTROPHIC MENTAL HEALTH INSURANCE COVERAGE

2000 GENERAL SESSION

STATE OF UTAH

Sponsor: Judy Ann Buffmire

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AN ACT RELATING TO INSURANCE; DEFINING TERMS; REQUIRING INSURERS TO OFFER EMPLOYERS A CHOICE OF MENTAL HEALTH COVERAGE; CREATING AN EXEMPTION FROM THE RATING BANDS FOR EMPLOYERS OF 20 OR LESS WHO CHOOSE CATASTROPHIC MENTAL HEALTH COVERAGE; PERMITTING INSURERS TO USE MANAGED CARE AND CLOSED PANELS IN PROVIDING CATASTROPHIC MENTAL HEALTH COVERAGE; EXTENDING RULEMAKING AUTHORITY TO THE INSURANCE COMMISSIONER; REQUIRING AN INTERIM REVIEW AND RECOMMENDATION; AND PROVIDING A REPEAL DATE.

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

AMENDS:

31A-22-617, as last amended by Chapters 314 and 316, Laws of Utah 1994

31A-22-618, as last amended by Chapter 204, Laws of Utah 1986

31A-30-106, as last amended by Chapter 265, Laws of Utah 1997

63-55-231, as last amended by Chapter 131, Laws of Utah 1999

ENACTS:

31A-22-625, Utah Code Annotated 1953

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

Section 1. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78-14-3 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by

an insurer. The health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person. The insurance contract may reward the insured for selection of preferred health care providers by reducing premium rates, reducing deductibles, coinsurance, or other copayments, or in any other reasonable manner.

(2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care provider contracts shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26 and 58.

(b) When the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers. The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.

(c) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(e) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(f) For purposes of this section, unfair discrimination between classes of health care providers shall include:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly utilized by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the grievance procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable

procedure for resolving complaints and grievances initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) No health care provider or insurer may discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Section 2. Section **31A-22-618** is amended to read:

31A-22-618. Nondiscrimination among health care professionals.

(1) Except as provided under Section 31A-22-617, and except as to insurers licensed under Chapter 8, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition falls within the coverage of the

contract. Upon the written request of an insured alleging an insurer has violated this section, the commissioner shall hold a hearing to determine if the violation exists. The commissioner may consolidate two or more related alleged violations into a single hearing.

(2) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Section 3. Section **31A-22-625** is enacted to read:

31A-22-625. Catastrophic coverage of mental health conditions.

(1) As used in this section:

(a) (i) "Catastrophic mental heath coverage" means coverage in a health insurance policy or health maintenance organization contract that does not impose any lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health insurance policy or health maintenance organization contract that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on episodic limits, inpatient or outpatient service limits, or maximum out-of-pocket limits.

(c) "Large employer" means an employer that does not come within the definition of "small employer."

(d) (i) "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as

periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) marital or family problem;

(B) social, occupational, religious, or other social maladjustment;

(C) conduct disorder;

(D) chronic adjustment disorder;

(E) psychosexual disorder;

(F) chronic organic brain syndrome;

(G) personality disorder;

(H) specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in Section 31A-30-103.

(2) (a) At the time of purchase and renewal, an insurer shall offer to each small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.

(b) In addition to Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, choose either catastrophic mental health coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the employer's previous coverage for mental health conditions.

(d) An insurer is exempt from the 30% index rating restriction in Subsection 31A-30-106(1)(b) and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in Subsection 31A-30-106(1)(c)(ii), for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) (a) At the time of purchase and renewal, an insurer shall offer catastrophic mental health coverage to each large employer that it insures or seeks to insure.

(b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental health coverage at levels that exceed the minimum requirements of this section.

(c) A large employer may, at its option, choose either catastrophic mental health coverage, coverage that excludes benefits for mental health conditions, or coverage offered under Subsection (3)(b).

(4) (a) An insurer may provide catastrophic mental health coverage through a managed care organization or system in a manner consistent with the provisions in Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide any benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility licensed or otherwise authorized to provide mental health services

pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may disapprove any policy or contract that provides mental heath coverage in a manner that is inconsistent with the provisions of this section.

(6) The commissioner shall:

(a) adopt rules as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of contracts and policies that include no mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and coverage that exceeds the minimum requirements of this section.

(7) The Health and Human Services Interim Committee shall review:

(a) the impact of this section on insurers, employers, providers, and consumers of mental health services before January 1, 2004; and

(b) make a recommendation as to whether the provisions of this section should be modified and whether the cost-sharing requirements for mental health conditions should be the same as for physical health conditions.

(8) (a) An insurer shall offer catastrophic mental health coverage as part of a health maintenance organization contract that is governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.

(b) An insurer shall offer catastrophic mental health coverage as a part of a health insurance policy that is not governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after July 1, 2001.

(c) This section does not apply to the purchase or renewal of an individual insurance policy or contract.

(d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as discouraging or otherwise preventing insurers from continuing to provide mental health coverage in connection with an individual policy or contract.

(9) This section shall be repealed in accordance with Section 63-55-231.

Section 4. Section **31A-30-106** is amended to read:

31A-30-106. Premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans under this chapter are subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%.

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the covered carrier is actively enrolling new covered insureds;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the covered carrier's rate manual for the class of business, except as provided in Section 31A-22-625; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the covered carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A covered carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.

(f) In the case of health benefit plans issued prior to July 1, 1994, a premium rate for a rating period, adjusted pro rata for rating period of less than a year, may exceed the ranges under Subsections (1)(a) and (b) until July 1, 1996. In that case, the percentage increase in the premium rate charged to a covered insured for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case where a covered carrier is not issuing any new policies the covered carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the covered carrier is actively enrolling new covered insureds; and

(ii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the carrier's rate manual for the class of business.

(g) The commissioner may grant a one-year extension of the July 1, 1996, deadline specified in Subsection (f) if the commissioner determines that an extension is needed to avoid significant disruption of the health insurance market subject to this chapter or to insure the financial stability of carriers in the market.

(h) (i) Covered carriers shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(ii) A covered carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(i) For the purposes of this subsection, a health benefit plan that utilizes a restricted network provision shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted network provision results in substantial difference

in claims costs.

(j) The covered carrier shall not, without prior approval of the commissioner, use case characteristics other than age, gender, industry, geographic area, family composition, and group size.

(k) The commissioner may establish regulations in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to implement the provisions of this chapter and to assure that rating practices used by covered carriers are consistent with the purposes of this chapter, including regulations that:

(i) assure that differences in rates charged for health benefit plans by covered carriers are reasonable and reflect objective differences in plan design (not including differences due to the nature of the groups assumed to select particular health benefit plans);

(ii) prescribe the manner in which case characteristics may be used by covered carriers;

(iii) require insurers, as a condition of transacting business with regard to health insurance disability policies after January 1, 1995, to reissue a health insurance disability policy to any policyholder whose insurance disability policy has, after January 1, 1994, been terminated by the insurer for reasons other than those listed in Subsections 31A-30-107(1)(a) through (1)(e) or not renewed by the insurer after January 1, 1994. The commissioner may prescribe terms for the reissue of coverage that the commissioner determines are reasonable and necessary to provide continuity of coverage to insured individuals;

(iv) implement the individual enrollment cap under Section 31A-30-110, including specifying the contents for certification, auditing standards, underwriting criteria for uninsurable classification, and limitations on high risk enrollees under Section 31A-30-111; and

(v) establish the individual enrollment cap under Subsection 31A-30-110(1).

(l) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 200% of that expected for a standard insurable individual with the same case characteristics.

(m) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605

regarding individual disability policy rates to allow rating in accordance with this section.

(2) A covered carrier shall not transfer a covered insured involuntarily into or out of a class of business. A covered carrier shall not offer to transfer a covered insured into or out of a class of business unless such offer is made to transfer all covered insureds in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

(3) Upon offering for sale any health benefit plan to a small employer, or individual, the covered carrier shall, as part of its solicitation and sales materials, disclose or make available all of the following:

(a) the extent to which premium rates for a specified covered insured are established or adjusted in part based on the actual or expected variation in claims costs or actual or expected variation in health status of covered individuals;

(b) provisions concerning the covered carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates;

(c) provisions relating to renewability of policies and contracts; and

(d) provisions relating to any preexisting condition provision.

(4) (a) Each covered carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each covered carrier shall file with the commissioner, on or before March 15 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that the covered carrier is in compliance with this chapter and that the rating methods of the covered carrier are actuarially sound. A copy of that certification shall be retained by the covered carrier at its principal place of business.

(c) A covered carrier shall make the information and documentation described in this subsection available to the commissioner upon request.

(d) Records submitted to the commissioner under the provisions of this section shall be maintained by the commissioner as protected records under Title 63, Chapter 2, Government Records

Access and Management Act.

Section 5. Section **63-55-231** is amended to read:

63-55-231. Repeal dates, Title 31A.

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2005.

(2) Section 31A-22-315, Motor Vehicle Insurance Reporting, is repealed July 1, 2000.

(3) Section 31A-22-625, Catastrophic Coverage of Mental Health Conditions, is repealed July 1, 2011.

[~~(3)~~] (4) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.