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H.B. 35
2nd Sub. (Gray)

Representative Judy Ann Buffmire proposes to substitute the following bill:

CATASTROPHIC MENTAL HEALTH INSURANCE COVERAGE

2000 GENERAL SESSION

STATE OF UTAH

Sponsor: Judy Ann Buffmire

AN ACT RELATING TO INSURANCE; DEFINING TERMS; REQUIRING HEALTH INSURERS TO OFFER MENTAL HEALTH COVERAGE THAT APPLIES THE SAME LIFETIME LIMITS, ANNUAL PAYMENT LIMITS, AND MAXIMUM OUT-OF-POCKET LIMITS TO MENTAL HEALTH CONDITIONS AS APPLY TO PHYSICAL HEALTH CONDITIONS; PERMITTING THE USE OF MANAGED CARE AND CLOSED PANELS; REQUIRING THAT SERVICES BE PROVIDED BY LICENSED THERAPISTS AND FACILITIES; IMPOSING DUTIES ON THE COMMISSIONER TO ADOPT RULES; REQUIRING AN INTERIM REVIEW AND RECOMMENDATION; IMPOSING REQUIREMENTS ON STATE EMPLOYEE HEALTH PLANS; 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

49-8-401, as last amended by Chapter 360, Laws of Utah 1998

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 mental health coverage as provided in 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 mental health coverage as provided in 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) "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.

(b) "Term or condition" means any lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, and maximum out-of-pocket limit.

(ii) "Term or condition" does not include any deductible, copayment, or coinsurance prior to reaching any maximum out-of-pocket limit.

(iii) Out-of-pocket expenses for mental health conditions and physical health conditions shall apply equally to any maximum out-of-pocket limit within a policy or contract.

(2) (a) At the time of purchase and renewal, an insurer shall offer to provide mental health coverage to each individual or group that it insurers or seeks to insurer, which, at a minimum, shall comply with Subsection (3).

(b) Individuals and groups may accept or reject an insurer's offer of mental health coverage

at the time of purchase and renewal, regardless of whether the individual or group has previously accepted or rejected such coverage.

(3) At a minimum, a health insurance policy or health maintenance contract that provides mental health coverage on or after January 1, 2001, may not establish any term or condition that places a greater financial burden on an insured for the diagnosis and treatment of a mental health condition than for the diagnosis and treatment of a covered physical health condition.

(4) (a) A policy or contract may provide coverage for the diagnosis and treatment of mental health conditions through a managed care organization or system, 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 under this section; 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)(d)(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 coverage under this section, 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 adopt rules as necessary to ensure compliance with 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 cost-sharing requirements for mental health conditions should be the same as for physical health conditions.

(8) Nothing in this section may be construed as restricting the ability of an insurer to offer mental health coverage that exceeds the requirements of this section.

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

Section 4. Section **49-8-401** is amended to read:

49-8-401. Group insurance division -- Powers and duties.

(1) The group insurance division of the retirement office shall:

(a) act as a self-insurer of employee group benefit plans and administer those plans;

(b) enter into contracts with private insurers to underwrite employee group benefit plans and to reinsure any appropriate self-insured plans;

(c) publish and disseminate descriptions of all employee benefit plans under this chapter in cooperation with the Department of Human Resource Management and political subdivisions;

(d) administer the process of claims administration of all employee benefit plans under this chapter or enter into contracts, after competitive bids are taken, with other benefit administrators to provide for the administration of the claims process;

(e) obtain an annual actuarial evaluation of all self-insured benefit plans and prepare an annual report for the governor and the Legislature describing the employee benefit plans being administered by the retirement office detailing historical and projected program costs and the status of reserve funds;

(f) consult with the Department of Human Resource Management and the executive bodies of other political subdivisions to evaluate employee benefit plans and develop recommendations for new or improved benefit plans;

(g) submit annually a budget which includes total projected benefit and administrative costs;

(h) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the self-funded employee group benefit plans as estimated by the board's consulting actuary;

(i) submit its recommended benefit adjustments for state employees upon approval of the board to the director of the Department of Human Resource Management. The Department of Human Resource Management shall include the benefit adjustments in the total compensation plan recommended to the governor required by Subsection 67-19-12(6)(a);

(j) adjust benefits, upon approval of the board, and upon appropriate notice to the state, its educational institutions, and political subdivisions;

(k) for the purposes of stimulating competition, establishing better geographical distribution of medical care services, and providing alternative health and dental plan coverage for both active and retired employees, request proposals for alternative health and dental coverage at least once every three years, proposals which meet the criteria specified in the request shall be offered to active and retired state employees and may be offered to active and retired employees of political subdivisions at the option of the political subdivision; [~~and~~]

(l) offer no less than two health plans to state employees that provide mental health coverage consistent with Section 31A-22-625; and

[~~(l)~~] (m) perform the same functions established in Subsections (1)(a), (b), (d), and (g) for the Department of Health if the group insurance division provides program benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40.

(2) Funds budgeted and expended shall accrue from premiums paid by the various employers. Administrative costs may not exceed that percentage of premium income which is recommended by the board and approved by the governor and the Legislature.

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) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.

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