

Senator Lane Beattie proposes to substitute the following bill:

1 **CATASTROPHIC MENTAL HEALTH INSURANCE COVERAGE**

2 2000 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: Judy Ann Buffmire**

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

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

14 AMENDS:

15 **31A-22-617**, as last amended by Chapters 314 and 316, Laws of Utah 1994

16 **31A-22-618**, as last amended by Chapter 204, Laws of Utah 1986

17 **31A-30-106**, as last amended by Chapter 265, Laws of Utah 1997

18 **63-55-231**, as last amended by Chapter 131, Laws of Utah 1999

19 ENACTS:

20 **31A-22-625**, Utah Code Annotated 1953

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

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

23 **31A-22-617. Preferred provider contract provisions.**

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

26 (1) Subject to restrictions under this section, any insurer or third party administrator may
27 enter into contracts with health care providers as defined in Section 78-14-3 under which the health
28 care providers agree to supply services, at prices specified in the contracts, to persons insured by
29 an insurer. The health care provider contract may require the health care provider to accept the
30 specified payment as payment in full, relinquishing the right to collect additional amounts from
31 the insured person. The insurance contract may reward the insured for selection of preferred health
32 care providers by reducing premium rates, reducing deductibles, coinsurance, or other copayments,
33 or in any other reasonable manner.

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

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

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

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

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

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

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

57 (ii) refusal to cover procedures for one class of providers that are:
58 (A) commonly utilized by members of the class of health care providers for the treatment
59 of illnesses, injuries, or conditions;
60 (B) otherwise covered by the insurer; and
61 (C) within the scope of practice of the class of health care providers.
62 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
63 to the insured that it has entered into preferred health care provider contracts. The insurer shall
64 provide sufficient detail on the preferred health care provider contracts to permit the insured to
65 agree to the terms of the insurance contract. The insurer shall provide at least the following
66 information:
67 (a) a list of the health care providers under contract and if requested their business
68 locations and specialties;
69 (b) a description of the insured benefits, including any deductibles, coinsurance, or other
70 copayments;
71 (c) a description of the quality assurance program required under Subsection (4); and
72 (d) a description of the grievance procedures required under Subsection (5).
73 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
74 assurance program for assuring that the care provided by the health care providers under contract
75 meets prevailing standards in the state.
76 (b) The commissioner in consultation with the executive director of the Department of
77 Health may designate qualified persons to perform an audit of the quality assurance program. The
78 auditors shall have full access to all records of the organization and its health care providers,
79 including medical records of individual patients.
80 (c) The information contained in the medical records of individual patients shall remain
81 confidential. All information, interviews, reports, statements, memoranda, or other data furnished
82 for purposes of the audit and any findings or conclusions of the auditors are privileged. The
83 information is not subject to discovery, use, or receipt in evidence in any legal proceeding except
84 hearings before the commissioner concerning alleged violations of this section.
85 (5) An insurer using preferred health care provider contracts shall provide a reasonable
86 procedure for resolving complaints and grievances initiated by the insureds and health care
87 providers.

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

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

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

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

102 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and
103 31A-22-618.

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

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

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

109 **31A-22-618. Nondiscrimination among health care professionals.**

110 (1) Except as provided under Section 31A-22-617, and except as to insurers licensed under
111 Chapter 8, no insurer may unfairly discriminate against any licensed class of health care providers
112 by structuring contract exclusions which exclude payment of benefits for the treatment of any
113 illness, injury, or condition by any licensed class of health care providers when the treatment is
114 within the scope of the licensee's practice and the illness, injury, or condition falls within the
115 coverage of the contract. Upon the written request of an insured alleging an insurer has violated
116 this section, the commissioner shall hold a hearing to determine if the violation exists. The
117 commissioner may consolidate two or more related alleged violations into a single hearing.

118 (2) This section does not apply to catastrophic mental health coverage provided in

119 accordance with Section 31A-22-625.

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

121 **31A-22-625. Catastrophic coverage of mental health conditions.**

122 (1) As used in this section:

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

128 (ii) "Catastrophic mental health coverage" does not include a restriction on cost sharing
129 factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum
130 out-of-pocket limit.

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

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

138 (ii) "50/50 mental health coverage" does not include a restriction on episodic limits,
139 inpatient or outpatient service limits, or maximum out-of-pocket limits.

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

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

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

147 (A) marital or family problem;

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

149 (C) conduct disorder;

150 (D) chronic adjustment disorder;

151 (E) psychosexual disorder;

152 (F) chronic organic brain syndrome

153 (G) personality disorder;

154 (H) specific developmental disorder or learning disability; or

155 (I) mental retardation.

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

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

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

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

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

164 (c) A small employer may, at its option, choose either catastrophic mental health coverage,
165 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the
166 employer's previous coverage for mental health conditions.

167 (d) An insurer is exempt from the 30% index rating restriction in Subsection
168 31A-30-106(1)(b) and, for the first year only that catastrophic mental health coverage is chosen,
169 the 15% annual adjustment restriction in Subsection 31A-30-106(1)(c)(ii), for any small employer
170 with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic
171 mental health coverage.

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

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

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

179 (4) (a) An insurer may provide catastrophic mental health coverage through a managed
180 care organization or system in a manner consistent with the provisions in Chapter 8, Health

181 Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract
182 uses a managed care organization or system for the treatment of physical health conditions.

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

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

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

186 unless:

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

188 and

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

190 (ii) If an insured receives services from a nonpanel provider in the manner permitted by

191 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average

192 amount paid by the insurer for comparable services of panel providers under a noncapitated

193 arrangement who are members of the same class of health care providers.

194 (iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize

195 a referral to a nonpanel provider.

196 (d) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a

197 mental health condition must be rendered:

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

199 (ii) in a health care facility licensed or otherwise authorized to provide mental health
200 services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or

201 Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the

202 treatment of a mental health condition pursuant to a written plan.

203 (5) The commissioner may disapprove any policy or contract that provides mental health

204 coverage in a manner that is inconsistent with the provisions of this section.

205 (6) The commissioner shall:

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

207 (b) provide general figures on the percentage of contracts and policies that include no
208 mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and

209 coverage that exceeds the minimum requirements of this section.

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

211 (a) the impact of this section on insurers, employers, providers, and consumers of mental

212 health services before January 1, 2004; and

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

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

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

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

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

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

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

229 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**

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

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

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

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

241 (i) the percentage change in the new business premium rate measured from the first day
242 of the prior rating period to the first day of the new rating period. In the case of a health benefit

243 plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier
244 shall use the percentage change in the base premium rate, provided that such change does not
245 exceed, on a percentage basis, the change in the new business premium rate for the most similar
246 health benefit plan into which the covered carrier is actively enrolling new covered insureds;

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

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

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

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

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

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

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

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

274 financial stability of carriers in the market.

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

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

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

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

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

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

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

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

304 (iv) implement the individual enrollment cap under Section 31A-30-110, including

305 specifying the contents for certification, auditing standards, underwriting criteria for uninsurable
306 classification, and limitations on high risk enrollees under Section 31A-30-111; and

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

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

313 (m) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605
314 regarding individual disability policy rates to allow rating in accordance with this section.

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

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

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

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

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

329 (d) provisions relating to any preexisting condition provision.

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

335 (b) Each covered carrier shall file with the commissioner, on or before March 15 of each

336 year, in a form, manner, and containing such information as prescribed by the commissioner, an
337 actuarial certification certifying that the covered carrier is in compliance with this chapter and that
338 the rating methods of the covered carrier are actuarially sound. A copy of that certification shall
339 be retained by the covered carrier at its principal place of business.

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

342 (d) Records submitted to the commissioner under the provisions of this section shall be
343 maintained by the commissioner as protected records under Title 63, Chapter 2, Government
344 Records Access and Management Act.

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

346 **63-55-231. Repeal dates, Title 31A.**

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

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

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

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