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H.B. 156
1st Sub. (Buff)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH INSURANCE ACCESSIBILITY

2006 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Michael G. Waddoups

LONG TITLE

General Description:

This bill amends provisions related to health insurance in the Insurance Code.

Highlighted Provisions:

This bill:

- clarifies that a health insurance policy or health maintenance organization policy may not deny a claim for emergency care for a covered evaluation, covered diagnostic test, or other covered treatment;
- amends the following provisions that permit an individual carrier to exclude specific physical conditions, diseases or disorders from medical insurance coverage:
  - adds specific disorders and diseases to the list of conditions that may be excluded;
  - expands the application of the exclusion to exclude both the specific condition and any complications from that condition; and
  - amends language related to secondary medical conditions that may or may not be directly related to the excluded condition;
- permits an individual carrier, at the carrier's option, to keep the exclusion rider in effect for the duration of the policy;
- clarifies the requirement for a health insurance policy to provide coverage for a

policyholder's unmarried disabled dependent; and

- amends the Utah mini-Cobra benefits coverage.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-22-611, as last amended by Chapters 73 and 116, Laws of Utah 2001

31A-22-627, as enacted by Chapter 142, Laws of Utah 2000

31A-22-722, as enacted by Chapter 108, Laws of Utah 2004

31A-30-107.5, as last amended by Chapter 78, Laws of Utah 2005

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

Section 1. Section **31A-22-611** is amended to read:

31A-22-611. Coverage for children with a disability.

[~~(1) Every accident and health insurance policy or contract that provides that coverage of a dependent child of a person insured under the policy shall:~~]

[~~(a) terminate upon reaching a limiting age as specified in the policy; and~~]

[~~(b) also provide that the age limitation does not terminate the coverage of a dependent child while the child is and continues to be both:~~]

[~~(i) incapable of self-sustaining employment because of mental retardation or physical disability; and (ii)~~]

(1) For the purposes of this section:

(a) "disabled dependent" means a child who is and continues to be both:

(i) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and

(ii) chiefly dependent upon [~~the person~~] an insured [~~under the policy~~] for support and maintenance since the child reached the age specified in Subsection 31A-22-610.5(2).

(b) "physical impairment" means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems:

(i) neurological;

(ii) musculoskeletal;

(iii) special sense organs;

(iv) respiratory organs;

(v) speech organs;

(vi) cardiovascular;

(vii) reproductive;

(viii) digestive;

(ix) genito-urinary;

(x) hemic and lymphatic;

(xi) skin; or

(xii) endocrine.

(c) "mental impairment" means a mental or psychological disorder such as:

(i) mental retardation;

(ii) organic brain syndrome;

(iii) emotional or mental illness; or

(iv) specific learning disabilities as determined by the insurer.

(2) The insurer may require proof of the incapacity and dependency be furnished by the person insured under the policy within 30 days of the effective date or the date the child attains the [~~limiting~~] age specified in Subsection 31A-22-610.5(2), and at any time thereafter, except that the insurer may not require proof more often than annually after the two-year period immediately following attainment of the limiting age by the [~~child~~] disabled dependent.

(3) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall, upon application, provide coverage for all unmarried disabled dependents who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age specified in Subsection 31A-22-610.5(2).

(4) Every accident and health insurance policy or contract that provides coverage of a disabled dependent shall not terminate the policy due to an age limitation.

Section 2. Section **31A-22-627** is amended to read:

31A-22-627. 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 covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured.

(2) 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. If such authorization is required, an insurer who does not accept or reject a request for authorization 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:

(a) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a hospital emergency department to result in:

(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part; and

(b) "hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

Section 3. Section **31A-22-722** is amended to read:

31A-22-722. Utah mini-COBRA benefits for employer group coverage.

(1) An insured has the right to extend the employee's coverage under the current employer's group policy for a period of six months, except as provided in Subsection (2). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) any disability;

(i) leave of absence; or

(j) reduction of hours.

(2) (a) Notwithstanding the provisions of Subsection (1), an employee does not have the right to extend coverage under the current employer's group policy if the employee:

(i) failed to pay any required individual contribution;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performed an act or practice that constitutes fraud in connection with the coverage;

(iv) made an intentional misrepresentation of material fact under the terms of the coverage;

(v) was terminated for gross misconduct;

(vi) has not been continuously covered under [~~a~~] the current employer's group policy for a period of six months immediately prior to the termination of the policy due to the events set forth in Subsection (1); or

(vii) is eligible for any extension of coverage required by federal law.

(b) The right to extend coverage under Subsection (1) applies to any spouse or dependent coverages, including a surviving spouse or dependents whose coverage under the policy terminates by reason of the death of the employee or member.

(3) (a) The employer shall provide written notification of the right to extend group

coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made to:

(i) the terminated insured;

(ii) the ex-spouse; or

(iii) if Subsection (2)(b) applies:

(A) to a surviving spouse; and

(B) the guardian of surviving dependents, if different from a surviving spouse.

(b) The notification shall be sent first class mail within 30 days after the termination date of the group coverage to:

(i) the terminated insured's home address as shown on the records of the employer;

(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;

(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and

(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in this Subsection (3) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and

(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.

(5) The premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(6) Except as provided in this Subsection (6), the coverage extends without interruption for six months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(a) elects to extend group coverage within 60 days of losing group coverage; and

(b) tenders the amount required to the employer or insurer.

(7) The insured's coverage may be terminated prior to six months if the terminated

insured:

(a) establishes residence outside of this state;

(b) moves out of the insurer's service area;

(c) fails to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(d) performs an act or practice that constitutes fraud in connection with the coverage;

(e) makes an intentional misrepresentation of material fact under the terms of the coverage;

(f) becomes eligible for similar coverage under another group policy; or

(g) employer's coverage is terminated, except as provided in Subsection (8).

(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have the right to obtain extension of coverage under the replacement group policy:

(a) for the balance of the period the terminated insured would have extended coverage under the replaced group policy; and

(b) if the terminated insured is otherwise eligible for extension of coverage.

(9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of the insured, the surviving spouse, or guardian of any dependents, written notification of the right to an individual conversion policy.

(b) The notification required by Subsection (9)(a):

(i) shall be sent first class mail to:

(A) the insured's last-known address as shown on the records of the employer;

(B) the address of the surviving spouse, if different from the insured's address, and if shown on the records of the employer;

(C) the guardian of any dependents last known address as shown on the records of the employer, if different from the address of the surviving spouse; and

(D) the address of the ex-spouse as shown on the records of the employer, if applicable; and

(ii) shall contain the name, address, and telephone number of the insurer that will

provide the conversion coverage.

Section 4. Section **31A-30-107.5** is amended to read:

31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.

(1) A health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).

(2) (a) [~~An~~] In accordance with Subsection (2)(b), an individual carrier:

(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:

(A) a specific physical condition[~~, or~~];

(B) a specific disease or disorder; and

(C) any specific or class of prescription drugs [~~consistent with Subsection (2)(b)~~]; and

(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including [~~specific~~] drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).

(b) (i) [~~The~~] Except as provided in Section 31A-22-630 Ŝ→ **and except for the treatment of asthma or when the condition is due to cancer** ←Ŝ , the following may be the subject of a condition-specific exclusion rider Ŝ→ **[~~except for the treatment of asthma or when~~]** ←Ŝ [~~a mastectomy has been performed or~~] Ŝ→ **[~~the condition is due to cancer~~]** ←Ŝ :

(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;

(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius, interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;

(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and [~~other~~] sinus related conditions, diseases, and disorders;

(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;

[~~(D)~~] (E) goiter and other thyroid related conditions[~~, hemangioma, hernia, keloids, migraines, scar revisions, varicose veins, abdominoplasty~~], diseases, or disorders;

[~~(E)~~] (F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;

(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;

[~~(F)~~] (H) Baker's cyst, ganglion cyst;

[~~(G) allergies; and~~]

(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;

(J) sleep disorders and speech disorders; and

[~~(H)~~] (K) any specific or class of prescription drugs.

(ii) A condition-specific exclusion rider:

(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;

(B) may not extend to any secondary medical condition [~~that may or may not be directly related to the excluded condition~~]; and

(C) must include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition [~~that may or may not be directly related to the excluded condition(s) herein~~], disease, or disorder."

(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.

Ŝ→ (d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6(9). ←Ŝ

(3) Notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:

(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation

period;

(b) the limitation period does not exceed 12 months;

(c) the limitation period is applied uniformly; and

(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b).

Fiscal Note

Bill Number HB0156S01

Health Insurance Accessibility

10-Feb-06

1:50 PM

State Impact

No fiscal impact.

Individual and Business Impact

The provision that allows purchasers of health insurance to waive certain conditions may allow more customers to stay with the private market. The addition of conditions that may be excluded may increase the cost of medical care for some.

Office of the Legislative Fiscal Analyst