

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



26 policyholder's unmarried disabled dependent; and
27 ▶ amends the Utah mini-Cobra benefits coverage.

28 **Monies Appropriated in this Bill:**

29 None

30 **Other Special Clauses:**

31 None

32 **Utah Code Sections Affected:**

33 AMENDS:

34 **31A-22-611**, as last amended by Chapters 73 and 116, Laws of Utah 2001

35 **31A-22-627**, as enacted by Chapter 142, Laws of Utah 2000

36 **31A-22-722**, as enacted by Chapter 108, Laws of Utah 2004

37 **31A-30-107.5**, as last amended by Chapter 78, Laws of Utah 2005



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

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

41 **31A-22-611. Coverage for children with a disability.**

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

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

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

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

49 (1) For the purposes of this section:

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

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

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

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

59 (i) neurological;

60 (ii) musculoskeletal;

61 (iii) special sense organs;

62 (iv) respiratory organs;

63 (v) speech organs;

64 (vi) cardiovascular;

65 (vii) reproductive;

66 (viii) digestive;

67 (ix) genito-urinary;

68 (x) hemic and lymphatic;

69 (xi) skin; or

70 (xii) endocrine.

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

72 (i) mental retardation;

73 (ii) organic brain syndrome;

74 (iii) emotional or mental illness; or

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

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

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

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

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

89 **31A-22-627. Coverage of emergency medical services.**

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

91 (a) require any form of preauthorization for treatment of an emergency medical

92 condition until after the insured's condition has been stabilized; or

93 (b) deny a claim for any covered evaluation, covered diagnostic test, or other covered
94 treatment considered medically necessary to stabilize the emergency medical condition of an
95 insured.

96 (2) A health insurance policy or health maintenance organization contract may require
97 authorization for the continued treatment of an emergency medical condition after the insured's
98 condition has been stabilized. If such authorization is required, an insurer who does not accept
99 or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing,
100 or other treatment considered medically necessary that occurred between the time the request
101 was received and the time the insurer rejected the request for authorization.

102 (3) For purposes of this section:

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

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

109 (ii) serious impairment to bodily functions; or

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

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

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

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

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

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

119 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

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

- 123 (a) voluntary termination;
- 124 (b) involuntary termination;
- 125 (c) retirement;
- 126 (d) death;
- 127 (e) divorce or legal separation;
- 128 (f) loss of dependent status;
- 129 (g) sabbatical;
- 130 (h) any disability;
- 131 (i) leave of absence; or
- 132 (j) reduction of hours.

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

- 135 (i) failed to pay any required individual contribution;
- 136 (ii) acquires other group coverage covering all preexisting conditions including
137 maternity, if the coverage exists;
- 138 (iii) performed an act or practice that constitutes fraud in connection with the coverage;
- 139 (iv) made an intentional misrepresentation of material fact under the terms of the
140 coverage;
- 141 (v) was terminated for gross misconduct;
- 142 (vi) has not been continuously covered under [a] the current employer's group policy
143 for a period of six months immediately prior to the termination of the policy due to the events
144 set forth in Subsection (1); or
- 145 (vii) is eligible for any extension of coverage required by federal law.

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

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

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

152 (i) the terminated insured;

153 (ii) the ex-spouse; or

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

155 (A) to a surviving spouse; and

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

157 (b) The notification shall be sent first class mail within 30 days after the termination

158 date of the group coverage to:

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

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

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

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

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

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

170 (b) the employee or other individual eligible for extension contacts the insurer within
171 60 days of coverage termination.

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

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

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

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

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

- 181 insured:
- 182 (a) establishes residence outside of this state;
- 183 (b) moves out of the insurer's service area;
- 184 (c) fails to pay premiums or contributions in accordance with the terms of the policy,
185 including any timeliness requirements;
- 186 (d) performs an act or practice that constitutes fraud in connection with the coverage;
- 187 (e) makes an intentional misrepresentation of material fact under the terms of the
188 coverage;
- 189 (f) becomes eligible for similar coverage under another group policy; or
- 190 (g) employer's coverage is terminated, except as provided in Subsection (8).
- 191 (8) If the current employer coverage is terminated and the employer replaces coverage
192 with similar coverage under another group policy, without interruption, the terminated insured,
193 spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have
194 the right to obtain extension of coverage under the replacement group policy:
- 195 (a) for the balance of the period the terminated insured would have extended coverage
196 under the replaced group policy; and
- 197 (b) if the terminated insured is otherwise eligible for extension of coverage.
- 198 (9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the
199 employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of
200 the insured, the surviving spouse, or guardian of any dependents, written notification of the
201 right to an individual conversion policy.
- 202 (b) The notification required by Subsection (9)(a):
- 203 (i) shall be sent first class mail to:
- 204 (A) the insured's last-known address as shown on the records of the employer;
- 205 (B) the address of the surviving spouse, if different from the insured's address, and if
206 shown on the records of the employer;
- 207 (C) the guardian of any dependents last known address as shown on the records of the
208 employer, if different from the address of the surviving spouse; and
- 209 (D) the address of the ex-spouse as shown on the records of the employer, if
210 applicable; and
- 211 (ii) shall contain the name, address, and telephone number of the insurer that will

212 provide the conversion coverage.

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

214 **31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion**
215 **riders -- Limitation periods.**

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

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

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

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

223 (B) a specific disease or disorder; and

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

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

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

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

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

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

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

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

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

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

249 ~~[(F)]~~ (H) Baker's cyst, ganglion cyst;
250 ~~[(G) allergies; and]~~

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

253 (J) sleep disorders and speech disorders; and

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

255 (ii) A condition-specific exclusion rider:

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

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

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

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

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

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

274 period;

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

276 (c) the limitation period is applied uniformly; and

277 (d) the limitation period is reduced in compliance with Subsections

278 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