LEGISLATIVE GENERAL COUNSEL
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S.B. 66
3rd Sub. (Ivory)

Senator Michael G. Waddoups proposes the following substitute bill:

EMPLOYER HEALTH INSURANCE OPTIONS - CAFETERIA PLANS

2007 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Michael G. Waddoups

House Sponsor: David Clark

Cosponsors:	Gene Davis	John W. Hickman
D. Chris Buttars	Margaret Dayton	Ed Mayne
Allen M. Christensen	Mike Dmitrich	Dennis E. Stowell

LONG TITLE

General Description:

This bill amends the Insurance Code to require certain health insurers to offer a point of service plan to employers and employees.

Highlighted Provisions:

This bill:

- defines terms;
- beginning January 1, 2008, requires health insurers to offer to employers a point of service plan;
- if an employer chooses a point of service plan, requires an insurer to inform employees of the point of service plan;
- permits an employer to pass the cost of a point of service plan on to the employee;
- establishes a reimbursement rate for noncontracted providers;
- establishes certain requirements for applying out-of-pocket expenses;
- prohibits an insurer from discriminating against a health care provider under

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contract with the insurer when the health care provider refers patients with a point of service plan out of network;

- requires the Insurance Department to report by November 2010 to the legislative Business and Labor Interim Committee concerning point of service plans in the state;
- coordinates requirements of the point of service plan with the preferred provider contract provisions; and
- makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill coordinates with H.B. 163, Options for Health Care, by substantively and technically modifying language.

Utah Code Sections Affected:

AMENDS:

31A-8-103, as last amended by Chapters 2 and 90, Laws of Utah 2004

ENACTS:

31A-22-635, Utah Code Annotated 1953

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

Section 1. Section **31A-8-103** is amended to read:

31A-8-103. Applicability to other provisions of law.

(1) (a) Except for exemptions specifically granted under this title, an organization is subject to regulation under all of the provisions of this title.

(b) Notwithstanding any provision of this title, an organization licensed under this chapter:

(i) is wholly exempt from:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations;

(B) Chapter 9, Insurance Fraternals;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund;

(F) Chapter 13, Employee Welfare Funds and Plans;

(G) Chapter 19a, Utah Rate Regulation Act; and

(H) Chapter 28, Guaranty Associations; and

(ii) is not subject to:

(A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1;

(B) Section 31A-4-107;

(C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for provisions specifically made applicable by this chapter;

(D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by this chapter;

(E) Chapter 17, Determination of Financial Condition, except:

(I) Parts 2 and 6; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

(F) Chapter 18, Investments, except as made applicable by the commissioner by rule consistent with this chapter; and

(G) Chapter 22, Contracts in Specific Lines, except for Parts 6, 7, and 12.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to health maintenance organizations or limited health plans, upon a finding that the waiver will not endanger the interests of:

(a) enrollees;

(b) investors; or

(c) the public.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as specifically made applicable by:

(a) this chapter;

(b) a provision referenced under this chapter; or

(c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an

organization, the application is:

(i) of those provisions that apply to a mutual corporation if the organization is nonprofit; and

(ii) of those that apply to a stock corporation if the organization is for profit.

(b) When Chapter 5 or 14 is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

(7) (a) Except as provided in Section 31A-8-501, and Subsection (7)(b), an organization is exempt from statutes in this title or department rules that restrict or limit the organization's freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

(b) An organization shall offer a point of service plan in compliance with Section 31A-22-635.

(8) An organization is exempt from the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

Section 2. Section **31A-22-635** is enacted to read:

31A-22-635. Offer of point of service plan.

(1) For purposes of this section:

(a) "Class of health care provider" means all health care providers as defined in Section 78-14-3:

(i) who are licensed or certified by the state under either:

(A) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(B) Title 58, Occupations and Professions; and

(ii) who are within the same professional, trade, occupational, or facility licensure or certification category established pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, and Title 58 Occupations and Professions.

(b) "Covered health care services" or "covered services" means health care services which an enrollee is entitled to receive under the terms of the insurance contract.

(c) "Employer" means an employer with 2 or more employees.

(d) "Point of service plan" means a health insurance plan or rider to a health insurance plan under which the insurer will reimburse a health care provider for providing covered services to an insured, without regard to whether the health care provider is a participating provider or belongs to the health insurance plan network.

(2) (a) This section applies to an insurer who is subject to:

(i) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(ii) Chapter 22, Part 6, Accident and Health Insurance;

(iii) Chapter 30, Individual, Small Employer, and Group Health Insurance Act, to the extent required by Subsection (1)(b); and

(iv) notwithstanding Section 31A-1-103, Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(b) This section does not apply when an individual's health maintenance organization benefit plan or health insurance plan is a Medicaid program or the Children's Health Insurance Program under Title 26, Chapter 18, Medicaid Assistance Act.

(3) (a) (i) Beginning with policies issued after or renewed after December 31, 2007, an insurer subject to Subsection (2)(a) shall offer at least one point of service plan in accordance with this section.

(ii) (A) An insurer shall offer a point of service plan to every employer which would allow an enrollee to receive covered services from out-of-network health care providers without having to obtain a referral or prior authorization from the insurer.

(B) An insurer shall provide each enrollee in a plan whose employer elects the point of service plan, with the opportunity, at the time of enrollment and during the open enrollment period, to enroll in the point of service plan. The insurer shall provide written notice of the point of service plan to each enrollee in a plan whose employer elects the point of service plan

and shall include in that notice a detailed explanation of the financial costs to be incurred by an enrollee who selects that plan.

(iii) The commissioner may audit any records necessary to determine compliance with this section.

(iv) An employer may chose to pay any, all, or no part of additional cost that is associated with an employee's selection of a point of service plan.

(b) The commissioner shall report to the Legislature's Business and Labor Interim Committee by November 1, 2010 concerning:

(i) the number of point of service plans offered in the state; and

(ii) the number of lives covered by point of service plans in the state.

(c) A point of service plan required by this section shall pay for covered services provided by a nonparticipating provider as follows:

(i) pay an amount equal to 75% of the average amount paid by the insurer for comparable services of participating providers who are members of the same class of health care provider;

(ii) pay the provider directly for the services; and

(iii) calculate and apply deductibles and cost sharing in accordance with Subsection (4).

(4) (a) A point of service plan subject to this section:

(i) may require an enrollee to pay the added costs associated with a point of service plan by paying:

(A) higher deductibles; and

(B) higher copayments or coinsurance; and

(ii) may not require an enrollee to pay a separate deductible.

(b) Copayments, coinsurance, and deductibles permitted by Subsection (4)(a):

(i) must be actuarially based; and

(ii) are subject to other limits established by the department by administrative rule adopted pursuant to Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(5) When an insured receives services from a nonparticipating provider who is reimbursed under the provisions of Subsection (3), the insured is responsible for:

(a) any copayments or deductibles that are imposed by the insurer under Subsection

(4); and

(b) in accordance with Subsection (6), the balance of provider charges that are not reimbursed by the insurer.

(6) Notwithstanding any other section of this title, a Ŝ→ **non-participating** ←Ŝ provider who accepts direct payment for health care services from an insurer may not Ŝ→ **:**

(a) ←Ŝ collect from an insured an amount that exceeds the insurer's average reimbursement rate described in Subsection (3)(c)(i) unless the insured has been informed of and agreed to in writing, the specific cost of the service Ŝ→ **; and**

(b) refer an insured to a facility or service in which the nonparticipating provider has a financial interest as described in Section 58-67-801, unless:

(i) the non-participating provider complies with the provisions of Section 58-67-801 by disclosing the provider's relationship in writing to the patient; and

(ii) the non-participating provider obtains a written agreement from the insured agreeing to the referral ←Ŝ .

(7) An insurer subject to this section may not discriminate against a health care provider based on a health care provider's referral patterns for patients who are covered by a point of service plan.

(8) (a) Except as provided in this Subsection (8) and Section 31A-8-103, an insurer regulated by Chapter 22, Part 6, Accident and Health Insurance, must comply with Section 31A-22-617.

(b) When reimbursing under a point of service plan required by this section:

(i) the reimbursement provisions of Subsection (3) of this section supercede the reimbursement provisions in Subsection 31A-22-617(2)(b);

(ii) the cost sharing provisions of Subsection (4) supercede Subsection 31A-22-617(2)(d); and

(iii) the requirement for payment directly to the provider in Subsection (3)(c)(ii) supercedes Subsection 31A-22-617(2)(c).

(9) The department may require an insurer to submit information to the department to demonstrate compliance with this section.

Section 3. **Coordinating H.B. 163 with S.B. 66 -- Modifying substantive language.**

If this S.B. 66 and H.B. 163 Options for Health Care, both pass, it is the intent of the Legislature that the Office of Legislative Research and General Counsel in preparing the Utah Code database for publication:

(1) delete Subsection 31A-22-635(8) in this bill, and renumber the remaining Subsection; and

(2) amend Section 31A-22-617 by inserting a new a Subsection 31A-22-617(10)(d) to read:

"(d) An insurer shall offer at least one policy that complies with Section 31A-22-635."

Fiscal Note

S.B. 66 3rd Sub. (Ivory) - Employer Health Insurance Options - Cafeteria Plans

2007 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations.

Individual, Business and/or Local Impact

For employers, the swing out option is voluntary and costs will vary. For employees selecting the option, insurers can charge higher deductibles, copayments and premuims.

2/14/2007, 3:11:44 PM, Lead Analyst: Eckersley, S.

Office of the Legislative Fiscal Analyst