House of Representatives *State of Utah*

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January 26, 2007

Mr. Speaker:

The Business and Labor Committee reports a favorable recommendation on **H.B. 295**, INSURANCE LAW AMENDMENTS, by Representative J. Dunnigan, with the following amendments:

1. *Page 1, Lines 18 through 19:*

▸ addresses independent review organizations;

▸ addresses requirements for the commissioner's adoption of a Basic Health Care Plan;

▸ addresses groups eligible for group or blanket insurance;

2. *Page 2, Lines 46 through 47:*

31A-22-610, as last amended by Chapter 252, Laws of Utah 2003

31A-22-613.5, as last amended by Chapter 114, Laws of Utah 2002

31A-22-629, as last amended by Chapter 78, Laws of Utah 2005

3. *Page 64, Lines 1966 through 1967:*

(iii) a child placed for adoption.

Section 10. Section 31A-22-613.5 is amended to read:

31A-22-613.5. Price and value comparisons of health insurance.

(1) This section applies generally to all health insurance policies and health maintenance organization contracts.

(2) [~~(a)~~] The commissioner shall adopt a Basic Health Care Plan consistent with this section to be offered under the open enrollment provisions of Chapter 30 , Individual, Small Employer, and Group Health Insurance Act .

[~~(b) (i) Before adoption of a plan under Subsection (2)(a), the commissioner shall submit the proposed Basic Health Care Plan to the Health and Human Services Interim Committee for review and recommendations.~~

~~(ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human Services Interim Committee:~~

~~(A) shall provide legislative oversight of the Basic Health Care Plan; and~~

~~(B) may recommend legislation to modify the Basic Health Care Plan adopted by the~~

~~commissioner.~~]

(3) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer issuing health insurance policies or health maintenance organization contracts to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, written disclosure of:

(i) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution; and

(ii) coverage limits under the plan.

(b) In addition to the requirements of Subsections (3)(a) and (d), an insurer described in Subsection (3)(a) shall submit the written disclosure required by this Subsection (3) to the commissioner:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (3)(a):

(A) treatment policies;

(B) practice standards;

(C) restrictions; or

(D) coverage limits of the insurer's health benefit plan or health insurance policy.

(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (3), taking into account:

(i) business confidentiality of the insurer;

(ii) definitions of terms; and

(iii) the method of disclosure to enrollees.

(d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included; and

(iii) any conditions that exist as a precedent to coverage.

(4) The Basic Health Care Plan adopted by the commissioner under this section shall provide for:

(a) a lifetime maximum benefit per person not to exceed $1,000,000;

(b) an annual maximum benefit per person not to exceed $300,000;

(c) an out-of-pocket maximum per person not to exceed $5,000, including the deductible;

(d) in relation to its cost-sharing features:

(i) a deductible of not less than $1,500 for major medical expenses; and
(ii)(A) a copayment of not less than:
(I) $25 per visit for office services; and
(II) $150 per visit to an emergency room; or
(B) coinsurance of not less than:
(I) 20% per visit for office services; and
(II) 20% per visit for an emergency room; and
(e) in relation to cost sharing features for prescription drugs:
(i) a deductible of not less than $500; and
(ii)(A) a copayment of not less than:
(I) $15 for the lowest level of cost for prescription drugs;
(II) $30 for the second level of cost for prescription drugs; and
(III) $60 for the highest level of cost for prescription drugs; or
(B) coinsurance of not less than:
(I) 25% for the lowest level of cost for prescription drugs;
(II) 40% for the second level of cost for prescription drugs; and
(III) 60% for the highest level of cost for prescription drugs.

Renumber remaining sections accordingly.

Respectfully,

Stephen D. Clark
Committee Chair

Voting: 10-0-3
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