LEGISLATIVE GENERAL COUNSEL
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S.B. 62

1 **HEALTH INSURANCE - MEDICAL**
2 **COMPLICATION EXCLUSIONS**
3 2008 GENERAL SESSION
4 STATE OF UTAH
5 **Chief Sponsor: Peter C. Knudson**
6 House Sponsor: Bradley G. Last
7
8 **LONG TITLE**
9 **General Description:**
10 This bill amends the Insurance Code to require a health insurer to provide notice to an
11 enrollee of the exclusion from coverage of a secondary medical condition resulting
12 from an excluded condition or procedure.
13 **Highlighted Provisions:**
14 This bill:
15 ▸ applies to health insurers in the state and to the Public Employee's Health Program;
16 ▸ beginning July 1, 2008, requires health insurers to give notice to enrollees that
17 coverage may be denied for secondary conditions resulting from a procedure, drug,
18 or condition that is excluded from coverage;
19 ▸ requires insurers to provide coverage for a secondary medical condition from
20 excluded coverage if the insurer fails to give an enrollee the notice required by
21 statute; and
22 ▸ makes technical amendments.
23 **Monies Appropriated in this Bill:**
24 None
25 **Other Special Clauses:**
26 None
27 **Utah Code Sections Affected:**

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28 AMENDS:
29 **31A-22-605.5**, as last amended by Laws of Utah 2003, Chapter 8
30 **31A-22-613.5**, as last amended by Laws of Utah 2007, Chapter 307
31 **31A-22-723**, as last amended by Laws of Utah 2005, Chapter 78
32

33 *Be it enacted by the Legislature of the state of Utah:*
34 Section 1. Section **31A-22-605.5** is amended to read:
35 **31A-22-605.5. Application.**
36 (1) For purposes of this section "insurance mandate":
37 (a) means a mandatory obligation with respect to coverage, benefits, or the number or
38 types of providers imposed on policies of accident and health insurance; and
39 (b) does not mean an administrative rule imposing a mandatory obligation with respect
40 to coverage, benefits, or providers unless that mandatory obligation was specifically imposed
41 on policies of accident and health insurance by statute.
42 (2) (a) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), [~~any law~~
43 ~~imposed under this title that becomes effective after January 1, 2002, which provides for an~~
44 ~~insurance mandate for policies of accident and health insurance shall also~~] the following shall
45 apply to health coverage offered to the state employees' risk pool under Subsection
46 49-20-202(1)(a)[~~.~~]:
47 (i) any law imposed under this title that becomes effective after January 1, 2002, which
48 provides for an insurance mandate for policies of accident and health insurance; and
49 (ii) in accordance with Section 31A-22-613.5, disclosure requirements for coverage
50 limitations.
51 (b) If health coverage offered to the state employees' risk pool under Subsection
52 49-20-202(1)(a) offers coverage in the same manner and to the same extent as the coverage
53 required by the insurance mandate imposed under this title or coverage that is greater than the
54 insurance mandate imposed under this title, the coverage offered to state employees under
55 Subsection 49-20-202(1)(a) will be considered in compliance with the insurance mandate.
56 (c) The program regulated under Subsection 49-20-202(1)(a) shall report to the
57 Retirement and Independent Entities Committee created under Section [~~63E-1-102~~] 63E-1-201
58 by November 30 of each year in which a mandate is imposed under the provisions of this

59 section. The report shall include the costs and benefits of the particular mandatory obligation.
60 Section 2. Section **31A-22-613.5** is amended to read:
61 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**
62 **Care Plan.**
63 (1) [~~This~~] (a) Except as provided in Subsection (1)(b), this section applies [~~generally~~]
64 to all health insurance policies and health maintenance organization contracts.
65 (b) Subsections (3) and (4) apply to:
66 (i) all health insurance policies and health maintenance organization contracts; and
67 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
68 (2) The commissioner shall adopt a Basic Health Care Plan consistent with this section
69 to be offered under the open enrollment provisions of Chapter 30, Individual, Small Employer,
70 and Group Health Insurance Act.
71 (3) (a) The commissioner shall promote informed consumer behavior and responsible
72 health insurance and health plans by requiring an insurer issuing health insurance policies or
73 health maintenance organization contracts to provide to all enrollees, prior to enrollment in the
74 health benefit plan or health insurance policy, and at each policy anniversary written disclosure
75 of:
76 (i) restrictions or limitations on prescription drugs and biologics including the use of a
77 formulary and generic substitution; [~~and~~]
78 (ii) coverage limits under the plan[~~.~~]; and
79 (iii) any limitation or exclusion of coverage including:
80 (A) a limitation or exclusion for a secondary medical condition related to a limitation
81 or exclusion from coverage; and
82 (B) easily understood examples of a limitation or exclusion of coverage for a secondary
83 medical condition.
84 (b) In addition to the requirements of Subsections (3)(a) [~~and~~], (d), and (e) an insurer
85 described in Subsection (3)(a) shall [~~submit~~] file the written disclosure required by this
86 Subsection (3) to the commissioner:
87 (i) upon commencement of operations in the state; and
88 (ii) anytime the insurer amends any of the following described in Subsection (3)(a):
89 (A) treatment policies;

90 (B) practice standards;
91 (C) restrictions; [or]
92 (D) coverage limits of the insurer's health benefit plan or health insurance policy[.]; or
93 (E) limitations or exclusions of coverage including a limitation or exclusion for a
94 secondary medical condition related to a limitation or exclusion of the insurer's health
95 insurance plan.
96 (c) The commissioner may adopt rules to implement the disclosure requirements of this
97 Subsection (3), taking into account:
98 (i) business confidentiality of the insurer;
99 (ii) definitions of terms; [and]
100 (iii) the method of disclosure to enrollees[.]; and
101 (iv) limitations and exclusions.
102 (d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available to
103 prospective enrollees and maintain evidence of the fact of the disclosure of:
104 (i) the drugs included;
105 (ii) the patented drugs not included; [and]
106 (iii) any conditions that exist as a precedent to coverage[.]; and
107 (iv) any exclusion from coverage for secondary medical conditions that may result
108 from the use of an excluded drug.
109 (e) (i) Beginning July 1, 2008, insurers subject to this Subsection (3) shall, in addition
110 to the notice of a limitation or exclusion of a coverage required at the time of enrollment under
111 Subsections (3)(a)(iii) and (d), provide notice to enrollees of any limitation of coverage or
112 excluded secondary medical condition when:
113 (A) an enrollee, or someone on the enrollee's behalf, contacts the insurer for
114 pre-authorization of a procedure or use of a drug that is excluded or limited from coverage; and
115 (B) the insurer sends the enrollee an explanation of benefits that identifies a procedure
116 or drug as an excluded or limited benefit.
117 (ii) The disclosure required by this Subsection (3)(e) shall:
118 (A) be delivered to the enrollee in writing;
119 (B) be in clear and plain language; and
120 (C) include examples of secondary medical conditions that:

121 (I) may result from use of the excluded procedure or drug; and
122 (II) would be limited or excluded from coverage.
123 (4) (a) If an insurer fails to provide the enrollee with the notice required by Subsection
124 (3)(e), the insurer may not deny coverage for the excluded secondary medical condition.
125 (b) An insurer:
126 (i) shall maintain evidence of the fact of disclosure under Subsection (3)(e); and
127 (ii) has the burden of proof to establish that notice was provided to the insured as
128 required by Subsection (3)(e).
129 [~~(4)~~] (5) The Basic Health Care Plan adopted by the commissioner under this section
130 shall provide for:
131 (a) a lifetime maximum benefit per person not to exceed $1,000,000;
132 (b) an annual maximum benefit per person not to exceed $300,000;
133 (c) an out-of-pocket maximum per person not to exceed $5,000, including the
134 deductible;
135 (d) in relation to its cost-sharing features:
136 (i) a deductible of not less than $1,500 for major medical expenses; and
137 (ii) (A) a copayment of not less than:
138 (I) $25 per visit for office services; and
139 (II) $150 per visit to an emergency room; or
140 (B) coinsurance of not less than:
141 (I) 20% per visit for office services; and
142 (II) 20% per visit for an emergency room; and
143 (e) in relation to cost-sharing features for prescription drugs:
144 (i) a deductible of not less than $500; and
145 (ii) (A) a copayment of not less than:
146 (I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for
147 prescription drugs;
148 (II) the lesser of the cost of the prescription drug or $30 for the second level of cost for
149 prescription drugs; and
150 (III) the lesser of the cost of the prescription drug or $60 for the highest level of cost
151 for prescription drugs; or

152 (B) coinsurance of not less than:
153 (I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for
154 prescription drugs;
155 (II) the lesser of the cost of the prescription drug or 40% for the second level of cost for
156 prescription drugs; and
157 (III) the lesser of the cost of the prescription drug or 60% for the highest level of cost
158 for prescription drugs.
159 Section 3. Section **31A-22-723** is amended to read:
160 **31A-22-723. Group and blanket conversion coverage.**
161 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection
162 (3), all policies of accident and health insurance offered on a group basis under this title, or
163 Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that
164 a person whose insurance under the group policy has been terminated is entitled to choose a
165 converted individual policy of similar accident and health insurance.
166 (2) A person who has lost group coverage may elect conversion coverage with the
167 insurer that provided prior group coverage if the person:
168 (a) has been continuously covered for a period of six months by the group policy or the
169 group's preceding policies immediately prior to termination;
170 (b) has exhausted either Utah mini-COBRA coverage as required in Section
171 31A-22-722 or federal COBRA coverage;
172 (c) has not acquired or is not covered under any other group coverage that covers all
173 preexisting conditions, including maternity, if the coverage exists; and
174 (d) resides in the insurer's service area.
175 (3) This section does not apply if the person's prior group coverage:
176 (a) is a stand alone policy that only provides one of the following:
177 (i) catastrophic benefits;
178 (ii) aggregate stop loss benefits;
179 (iii) specific stop loss benefits;
180 (iv) benefits for specific diseases;
181 (v) accidental injuries only;
182 (vi) dental; or

183 (vii) vision;
184 (b) is an income replacement policy;
185 (c) was terminated because the insured:
186 (i) failed to pay any required individual contribution;
187 (ii) performed an act or practice that constitutes fraud in connection with the coverage;
188 or
189 (iii) made intentional misrepresentation of material fact under the terms of coverage; or
190 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or
191 31A-30-107(2)(a).
192 (4) (a) The employer shall provide written notification of the right to an individual
193 conversion policy within 30 days of the insured's termination of coverage to:
194 (i) the terminated insured;
195 (ii) the ex-spouse; or
196 (iii) in the case of the death of the insured:
197 (A) the surviving spouse; and
198 (B) the guardian of any dependents, if different from a surviving spouse.
199 (b) The notification required by Subsection (4)(a) shall:
200 (i) be sent by first class mail;
201 (ii) contain the name, address, and telephone number of the insurer that will provide
202 the conversion coverage; and
203 (iii) be sent to the insured's last-known address as shown on the records of the
204 employer of:
205 (A) the insured;
206 (B) the ex-spouse; and
207 (C) if the policy terminates by reason of the death of the insured to:
208 (I) the surviving spouse; and
209 (II) the guardian of any dependents, if different from a surviving spouse.
210 (5) (a) An insurer is not required to issue a converted policy which provides benefits in
211 excess of those provided under the group policy from which conversion is made.
212 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health
213 benefit plan, the employee or member must be offered at least the basic benefit plan as

214 provided in [~~Subsection~~] Section 31A-22-613.5[~~(2)(a)~~].
215 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels
216 provided under the group policy, the conversion policy may offer benefits which are
217 substantially similar to those provided under the group policy.
218 (6) Written application for the converted policy shall be made and the first premium
219 paid to the insurer no later than 60 days after termination of the group accident and health
220 insurance.
221 (7) The converted policy shall be issued without evidence of insurability.
222 (8) (a) The initial premium for the converted policy for the first 12 months and
223 subsequent renewal premiums shall be determined in accordance with premium rates
224 applicable to age, class of risk of the person, and the type and amount of insurance provided.
225 (b) The initial premium for the first 12 months may not be raised based on pregnancy
226 of a covered insured.
227 (c) The premium for converted policies shall be payable monthly or quarterly as
228 required by the insurer for the policy form and plan selected, unless another mode or premium
229 payment is mutually agreed upon.
230 (9) The converted policy becomes effective at the time the insurance under the group
231 policy terminates.
232 (10) (a) A newly issued converted policy covers the employee or the member and must
233 also cover all dependents covered by the group policy at the date of termination of the group
234 coverage.
235 (b) The only dependents that may be added after the policy has been issued are children
236 and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).
237 (c) At the option of the insurer, a separate converted policy may be issued to cover any
238 dependent.
239 (11) (a) To the extent the group policy provided maternity benefits, the conversion
240 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group
241 policy or the conversion policy until termination of a pregnancy that exists on the date of
242 conversion if one of the following is pregnant on the date of the conversion:
243 (i) the insured;
244 (ii) a spouse of the insured; or

245 (iii) a dependent of the insured.
246 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs
247 after the date of conversion.
248 (12) Except as provided in this Subsection (12), a converted policy is renewable with
249 respect to all individuals or dependents at the option of the insured. An insured may be
250 terminated from a converted policy for the following reasons:
251 (a) a dependent is no longer eligible under the policy;
252 (b) for a network plan, if the individual no longer lives, resides, or works in:
253 (i) the insured's service area; or
254 (ii) the area for which the covered carrier is authorized to do business; [~~or~~]
255 (c) the individual fails to pay premiums or contributions in accordance with the terms
256 of the converted policy, including any timeliness requirements;
257 (d) the individual performs an act or practice that constitutes fraud in connection with
258 the coverage;
259 (e) the individual makes an intentional misrepresentation of material fact under the
260 terms of the coverage; or
261 (f) coverage is terminated uniformly without regard to any health status-related factor
262 relating to any covered individual.
263 (13) Conditions pertaining to health may not be used as a basis for classification under
264 this section.

Legislative Review Note
as of 12-7-07 6:45 AM

Office of Legislative Research and General Counsel

S.B. 62 - Health Insurance - Medical Complication Exclusions

Fiscal Note

2008 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations.

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals, businesses, or local governments.