HEALTH AMENDMENTS

2010 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: David Clark

Senate Sponsor: Wayne L. Niederhauser

LONG TITLE

General Description:

This bill amends provisions related to transparency and health benefits in the Insurance Code and the Medicaid program.

Highlighted Provisions:

This bill:

- requires accountability and transparency from the state Medicaid program;
- requires an insurer to provide information to consumers regarding health insurance policies; and
- requires greater choice of benefit plans for employers in the defined contribution market of the health insurance exchange.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill provides an effective date.

This bill coordinates with H.B. 294, Health System Reform Amendments, by substantively superseding a provision.

This bill coordinates with H.B. 39, Insurance Related Amendments, by providing substantive changes.

Utah Code Sections Affected:

AMENDS:

26-18-2.3, as last amended by Laws of Utah 2006, Chapter 46

26-18-3, as last amended by Laws of Utah 2008, Chapters 62 and 382

31A-22-613.5, as last amended by Laws of Utah 2009, Chapter 12

31A-22-722.5, as enacted by Laws of Utah 2009, Chapter 274

31A-30-205, as enacted by Laws of Utah 2009, Chapter 12

Utah Code Sections Affected by Coordination Clause:

31A-22-613.5, as last amended by Laws of Utah 2009, Chapter 12

31A-22-722.5, as enacted by Laws of Utah 2009, Chapter 274

31A-30-205, as enacted by Laws of Utah 2009, Chapter 12

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

Section 1. Section **26-18-2.3** is amended to read:

26-18-2.3. Division responsibilities -- Emphasis -- Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:

(a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;

(b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and

(c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

(2) The division shall implement and utilize cost-containment methods, where possible, which may include[~~, but are not limited to~~]:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) consistent with Sections 26-18-2.4 and 58-17b-606, a Medicaid drug program;

(g) coordination of benefits; and

(h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

(4) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery, at least in proportion to the percent of funding for the program that comes from state funds.

(5) The department shall, by December 31 of each year, report to the Health and Human Services Appropriations Subcommittee regarding:

(a) measures taken under this section to increase:

(i) efficiencies within the program; and

(ii) cost avoidance and cost recovery efforts in the program; and

(b) results of program integrity efforts under Subsection (4).

Section 2. Section **26-18-3** is amended to read:

26-18-3. Administration of Medicaid program by department -- Reporting to the Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility standards.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) (a) The department shall implement the Medicaid program through administrative

rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the requirements of Title XIX, and applicable federal regulations.

(b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules necessary to implement the program:

(i) the standards used by the department for determining eligibility for Medicaid services;

(ii) the services and benefits to be covered by the Medicaid program; and

(iii) reimbursement methodologies for providers under the Medicaid program.

(3) (a) The department shall, in accordance with Subsection (3)(b), report to either the Legislative Executive Appropriations Committee or the Legislative Health and Human Services Appropriations Subcommittee when the department:

(i) implements a change in the Medicaid State Plan;

(ii) initiates a new Medicaid waiver;

(iii) initiates an amendment to an existing Medicaid waiver; [~~or~~]

(iv) applies for an extension of an application for a waiver or an existing Medicaid waiver; or

[~~(iv)~~] (v) initiates a rate change that requires public notice under state or federal law.

(b) The report required by Subsection (3)(a) shall:

(i) be submitted to the Legislature's Executive Appropriations Committee or the legislative Health and Human Services Appropriations Subcommittee prior to the department implementing the proposed change; and

(ii) [~~shall~~] include:

(A) a description of the department's current practice or policy that the department is proposing to change;

(B) an explanation of why the department is proposing the change;

(C) the proposed change in services or reimbursement, including a description of the effect of the change;

(D) the effect of an increase or decrease in services or benefits on individuals and

families;

(E) the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and

(F) the fiscal impact of the proposed change, including:

(I) the effect of the proposed change on current or future appropriations from the Legislature to the department;

(II) the effect the proposed change may have on federal matching dollars received by the state Medicaid program;

(III) any cost shifting or cost savings within the department's budget that may result from the proposed change; and

(IV) identification of the funds that will be used for the proposed change, including any transfer of funds within the department's budget.

(4) Any rules adopted by the department under Subsection (2) are subject to review and reauthorization by the Legislature in accordance with Section 63G-3-502.

(5) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including:

(a) the determination of the eligibility of individuals for the program;

(b) recovery of overpayments; and

(c) consistent with Section 26-20-13, and to the extent permitted by law and quality control services, enforcement of fraud and abuse laws.

(6) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(7) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX

of the federal Social Security Act shall be deposited in the General Fund as nonlapsing dedicated credits to be used by the division in accordance with the requirements of Section 1919 of Title XIX of the federal Social Security Act.

(8) (a) In determining whether an applicant or recipient is eligible for a service or benefit under this part or Chapter 40, Utah Children's Health Insurance Act, the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.

(b) Before Subsection (8)(a) may be applied:

(i) the federal government must:

(A) determine that Subsection (8)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;

(B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or

(C) determine that the state's waivers that permit dual eligibility determinations for cash assistance and Medicaid are no longer valid; and

(ii) the department must determine that Subsection (8)(a) can be implemented within existing funding.

(9) (a) For purposes of this Subsection (9):

(i) "aged, blind, or disabled" shall be defined by administrative rule; and

(ii) "spend down" means an amount of income in excess of the allowable income standard that must be paid in cash to the department or incurred through the medical services not paid by Medicaid.

(b) In determining whether an applicant or recipient who is aged, blind, or disabled is eligible for a service or benefit under this chapter, the department shall use 100% of the federal poverty level as:

(i) the allowable income standard for eligibility for services or benefits; and

(ii) the allowable income standard for eligibility as a result of spend down.

Section 3. Section **31A-22-613.5** is amended to read:

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

Care Plan.

(1) (a) [~~Except as provided in Subsection (1)(b), this~~] This section applies to all health [~~insurance policies and health maintenance organization contracts~~] benefit plans.

(b) Subsection (2) applies to:

(i) all [~~health insurance policies and health maintenance organization contracts~~] health benefit plans; and

(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) (a) The commissioner shall promote informed consumer behavior and responsible [~~health insurance and~~] health benefit plans by requiring an insurer issuing [~~health insurance policies or health maintenance organization contracts~~] a health benefit plan to:

(i) provide to all enrollees, prior to enrollment in the health benefit plan [~~or health insurance policy,~~] written disclosure of:

[~~(i)~~] (A) restrictions or limitations on prescription drugs and biologics including:

(I) the use of a formulary [~~and~~];

(II) co-payments and deductibles for prescription drugs; and

(III) requirements for generic substitution;

[~~(ii)~~] (B) coverage limits under the plan; and

[~~(iii)~~] (C) any limitation or exclusion of coverage including:

[~~(A)~~] (I) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

[~~(B)~~] (II) [~~beginning July 1, 2009,~~] easily understood examples of a limitation or exclusion of coverage for a secondary medical condition[~~.~~]; and

(ii) provide the commissioner with:

(A) the information described in Subsections 63M-1-2506(3) through (6) in the standardized electronic format required by Subsection 63M-1-2506(1); and

(B) information regarding insurer transparency in accordance with Subsection (5).

(b) [~~In addition to the requirements of Subsections (2)(a), (d), and (e) an insurer described in Subsection (2)(a) shall file the written~~] An insurer shall provide the disclosure

required by [~~this~~] Subsection (2)(a)(i) [~~to the commissioner:~~] in writing to the commissioner:

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

(ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):

(A) treatment policies;

(B) practice standards;

(C) restrictions;

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

(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

[~~(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (2), taking into account:~~]

[~~(i) business confidentiality of the insurer;~~]

[~~(ii) definitions of terms;~~]

[~~(iii) the method of disclosure to enrollees; and~~]

[~~(iv) limitations and exclusions.~~]

(c) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

(d) If under Subsection (2)(a)(i)(A) 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;

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

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

(e) (i) The department shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)[~~(iii)~~](i)(C).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)[~~(iii)~~](i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(3) An insurer who offers a health [~~care~~] benefit plan under Chapter 30, Individual, Small Employer, and Group Health Insurance Act, shall[~~: (a) until January 1, 2010, offer the basic health care plan described in Subsection (4) subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and (b) beginning January 1, 2010,~~] offer a basic health care plan subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:

[~~(i)~~] (a) is a federally qualified high deductible health plan;

[~~(ii)~~] (b) has [~~the lowest~~] a deductible that is within $250 of the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and

[~~(iii)~~] (c) does not exceed an annual out of pocket maximum equal to three times the amount of the annual deductible.

[~~(4) Until January 1, 2010, the Basic Health Care Plan under this section shall provide for:~~]

[~~(a) a lifetime maximum benefit per person not less than $1,000,000;~~]

[~~(b) an annual maximum benefit per person not less than $250,000;~~]

[~~(c) an out-of-pocket maximum of cost-sharing features:~~]

[~~(i) including:~~]

[~~(A) a deductible;~~]

[~~(B) a copayment; and~~]

[~~(C) coinsurance;~~]

[~~(ii) not to exceed $5,000 per person; and~~]

[~~(iii) for family coverage, not to exceed three times the per person out-of-pocket maximum provided in Subsection (4)(c)(ii);~~]

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

[~~(i) a deductible of:~~]

[~~(A) not less than $1,000 per person for major medical expenses; and~~]

[~~(B) for family coverage, not to exceed three times the per person deductible for major medical expenses under Subsection (4)(d)(i)(A); 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) a deductible not to exceed $1,000 per person; and~~]

[~~(B) for family coverage, not to exceed three times the per person deductible provided in Subsection (4)(e)(i)(A); and~~]

[~~(ii) (A) a copayment of not less than:~~]

[~~(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;~~]

[~~(II) the lesser of the cost of the prescription drug or $25 for the second level of cost for prescription drugs; and~~]

[~~(III) the lesser of the cost of the prescription drug or $35 for the highest level of cost for prescription drugs; or~~]

[~~(B) coinsurance of not less than:~~]

[~~(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for~~

~~prescription drugs;~~]

[~~(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and~~]

[~~(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.~~]

[~~(5) The department shall include in its yearly insurance market report information about:~~]

[~~(a) the types of health benefit plans sold on the Internet portal created in Section 63M-1-2504;~~]

[~~(b) the number of insurers participating in the defined contribution market on the Internet portal;~~]

[~~(c) the number of employers and covered lives in the defined contribution market; and~~]

[~~(d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).~~]

[~~(6)~~] (4) The commissioner:

(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Section 63M-1-2504; and

(b) may request information from an insurer to verify the information submitted by the insurer [~~to the Internet portal under Subsection 63M-1-2506(4)~~] under this section.

(5) The commissioner shall:

(a) convene a group of insurers, a member representing the Public Employees' Benefit and Insurance Program, consumers, and an organization described in Subsection 31A-22-614.6(3)(b), to develop information for consumers to compare health insurers and health benefit plans on the Health Insurance Exchange, which shall include consideration of:

(i) the number and cost of an insurer's denied health claims;

(ii) the cost of denied claims that is transferred to providers;

(iii) the average out-of-pocket expenses incurred by participants in each health benefit

plan that is offered by an insurer in the Health Insurance Exchange;

(iv) the relative efficiency and quality of claims administration and other administrative processes for each insurer offering plans in the Health Insurance Exchange; and

(v) consumer assessment of each insurer or health benefit plan;

(b) adopt an administrative rule that establishes:

(i) definition of terms;

(ii) the methodology for determining and comparing the insurer transparency information;

(iii) the data, and format of the data, that an insurer must submit to the department in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(iv) the dates on which the insurer must submit the data to the department in order for the department to transmit the data to the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(c) implement the rules adopted under Subsection (5)(b) in a manner that protects the business confidentiality of the insurer.

Section 4. Section **31A-22-722.5** is amended to read:

31A-22-722.5. Mini-COBRA election -- American Recovery and Reinvestment Act.

(1) [~~An~~] (a) If the provisions of Subsection (1)(b) are met, an individual has a right[~~,~~ ~~until April 18, 2009,~~] to contact the individual's employer or the insurer for the employer to participate in a [~~second election~~] transition period for mini-COBRA benefits under Section 31A-22-722 in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 111-5) [~~if the individual:~~], as amended.

[~~(a) was~~] (b) An individual has the right under Subsection (1)(a) if the individual:

(i) was involuntarily terminated from employment [~~between September 1, 2008 and February 17, 2009, as defined~~] during the period of time identified in Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 111-5), as amended;

[~~(b)~~] (ii) is eligible for COBRA premium assistance under Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 111-5), as amended; [~~and~~]

[~~(c)~~] (iii) was eligible for Utah mini-COBRA as provided in Section 31A-22-722 at the time of termination[~~.~~];

(iv) elected Utah mini-Cobra; and

(v) voluntarily dropped coverage, which includes dropping coverage through non-payment of premiums, between December 1, 2009 and February 1, 2010.

(2) (a) An individual or the employer of the individual shall contact the insurer and inform the insurer that the individual wants to [~~take advantage of the second election~~] maintain coverage and pay retroactive premiums under a transition period for mini-COBRA coverage [~~under~~] in accordance with the provisions of Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 111-5), as amended.

(b) An individual or an employer on behalf of an eligible individual must submit the [~~enrollment forms~~] applicable forms and premiums for coverage under Subsection (1) to the insurer [~~prior to May 1, 2009~~] in accordance with the provisions of Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 11-5), as amended.

(3) [~~The provision regarding the application of pre-existing condition waivers to the extended second election period for federal COBRA under Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 111-5) shall apply to the extended second election for state mini-COBRA under this section.~~] An insured has the right to extend the employee's coverage under mini-cobra with the current employer's group policy beyond the 12 months to the period of time the insured is eligible to receive assistance in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. S. 111-5) as amended.

(4) An insurer that violates this section is subject to penalties in accordance with Section 31A-2-308.

Section 5. Section **31A-30-205** is amended to read:

31A-30-205. Health benefit plans offered in the defined contribution market.

(1) An insurer who [~~chooses to offer a health benefit plan in the~~] offers a defined contribution [~~market must~~] arrangement health benefit plan shall offer the following health benefit plans as defined contribution arrangements:

[~~(a) one health benefit plan that:~~]

[~~(i) is a federally qualified high deductible health plan;~~]

[~~(ii) has the lowest deductible permitted for a federally qualified high deductible health plan as adjusted by federal law; and~~]

[~~(iii) does not exceed annual out-of-pocket maximum equal to three times the amount of the annual deductible; and~~]

(a) the basic benefit plan;

(b) one health benefit plan with [~~benefits that have~~] an aggregate actuarial value at least 15% greater [~~that~~] than the [~~plan described in Subsection (1)(a).~~] actuarial value of the basic benefit plan;

(c) on or before January 1, 2011, one health benefit plan that is a federally qualified high deductible health plan that has an individual deductible of $2,500 and a deductible of $5,000 for coverage including two or more individuals, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible;

(d) on or before January 1, 2011, one health benefit plan that is a federally qualified high deductible health plan that has a deductible that is within $250 of the highest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible; and

(e) the insurer's five most commonly selected health benefit plans that:

(i) include:

(A) the provider panel;

(B) the deductible;

(C) co-payments;

(D) co-insurance; and

(E) pharmacy benefits; and

(ii) are currently being marketed by the carrier to new groups for enrollment.

(2) (a) The provisions of Subsection (1) do not limit the number of defined contribution arrangement health benefit plans an insurer may offer in the defined contribution arrangement market.

(b) An insurer who offers the health benefit plans required by Subsection (1) may also offer any other health benefit plan [~~in the~~] as a defined contribution [~~market~~] arrangement if:

(i) the health benefit plan provides benefits that are [~~actuarially richer~~] of greater actuarial value than the benefits required in [~~Subsection (1)(a).~~] the basic benefit plan; or

(ii) the health benefit plan provides benefits with an aggregate actuarial value that is no lower than the actuarial value of the plan required in Subsection (1)(c).

Section 6. **Effective date.**

If approved by two-thirds of all the members elected to each house, this bill takes effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override.

Section 7. **Coordinating H.B. 459 with H.B. 294 -- Superseding amendments.**

If this H.B. 459 and H.B. 294, Health System Reform Amendments, both pass, it is the intent of the Legislature that the amendments to Sections 31A-22-613.5 and 31A-30-205 in this bill supersede the amendments to Sections 31A-22-613.5 and 31A-30-205 in H.B. 294, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.

Section 8. **Coordinating H.B. 459 with H.B. 39 -- Substantive changes.**

If this H.B. 459 and H.B. 39, Insurance Related Amendments, both pass, it is the intent of the Legislature that the amendments to Section 31A-22-722.5 in this bill supersede the amendments to Section 31A-22-722.5 in H.B. 39, and has retrospective operation to the date the governor signed H.B. 39, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.

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