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INSURANCE COVERAGE FOR AMINO ACID-BASED FORMULA

2011 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Carol Spackman Moss

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends the Insurance Code to require coverage for the use of an amino acid-based elemental formula, regardless of the delivery method of the formula, for the diagnosis or treatment of an eosinophilic gastrointestinal disorder.

Highlighted Provisions:

This bill:

- defines terms;
- requires that a health benefit plan shall provide coverage for the use of an amino acid-based elemental formula, regardless of the delivery method of the formula, for the diagnosis or treatment of an eosinophilic gastrointestinal disorder if a licensed physician issues a written order stating that the formula is medically necessary;
- grants rulemaking authority to the Insurance Commissioner;
- requires the coverage described in this bill to be similar to, or identical to, the coverage provided for other illnesses or diseases;
- provides that exemptions to insurance coverage mandates for health benefit plans do not apply to the insurance coverage described in this bill; and
- makes technical changes.

Money Appropriated in this Bill:

None

H.B. 233

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-22-618.5, as last amended by Laws of Utah 2010, Chapter 68

31A-22-724, as enacted by Laws of Utah 2009, Chapter 12

ENACTS:

31A-22-640, Utah Code Annotated 1953

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

Section 1. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Health benefit plan offerings.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(D) except for the insurance coverage required in Section 31A-22-640, coverage mandates enacted after January 1, 2009, that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency

medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from non-affiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:

(i) tier one contracted providers;

(ii) tier two contracted providers who the insurer must reimburse at least 75% of tier one providers; and

(iii) one or more tiers of non-contracted providers; and

(b) notwithstanding Subsection 31A-22-617(9) may offer a health benefit plan that is not subject to Section 31A-22-618;

(c) beginning July 1, 2012, may offer products under Subsection (3)(a) that:

(i) are not subject to Subsection 31A-22-617(2); and

(ii) are subject to the reimbursement requirements in Section 31A-8-501;

(d) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 by providing coverage at a reimbursement level of at least 75% of tier one providers; and

(e) except for the insurance coverage required in Section 31A-22-640, are not subject to coverage mandates enacted after January 1, 2009, that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsections (3)(a) and (b) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 2. Section **31A-22-640** is enacted to read:

31A-22-640. Insurance coverage for amino acid-based formula.

(1) As used in this section:

(a) "Amino acid-based elemental formula" means a nutrition formula:

(i) made from individual non-allergenic amino acids that are broken down to enhance absorption and digestion; and

(ii) designed for individuals who have a dysfunctional gastrointestinal tract and are unable to tolerate and absorb whole foods or formulas composed of whole proteins, fats, or carbohydrates.

(b) (i) "Eosinophilic gastrointestinal disorder" means a disorder characterized by having above normal amounts of eosinophils in one or more specific places anywhere in the digestive system.

(ii) "Eosinophilic gastrointestinal disorder" includes:

(A) eosinophilic esophagitis;

(B) eosinophilic gastritis;

(C) eosinophilic gastroenteritis;

(D) eosinophilic enteritis; and

(E) eosinophilic colitis.

(2) A health benefit plan shall provide coverage for the use of an amino acid-based elemental formula, regardless of the delivery method of the formula, for the diagnosis or treatment of an eosinophilic gastrointestinal disorder if a licensed physician issues a written order stating that the use of an amino acid-based elemental formula is medically necessary.

(3) The commissioner shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that set minimum standards for the coverage described in Subsection (2).

(4) The rules described in Subsection (3) shall require that all cost sharing provisions for the coverage described in Subsection (2), including deductibles, coinsurance, annual

maximums, and lifetime maximums, are similar to, or identical to, the coverage provided for other illnesses or diseases.

Section 3. Section **31A-22-724** is amended to read:

31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.

(1) For purposes of this section, "alternative coverage" means:

(a) the high deductible or low deductible Utah NetCare Plan described in Subsection (2) for conversion policies offered under Section 31A-22-723; and

(b) the high deductible and low deductible Utah NetCare Plans described in Subsection (2) as an alternative to COBRA and mini-COBRA policies offered under Section 31A-22-722.

(2) The Utah NetCare Plans shall include:

(a) healthy lifestyle and wellness incentives;

(b) the benefits described in this Subsection (2) or at least the actuarial equivalent of the benefits described in this Subsection (2);

(c) a lifetime maximum benefit per person of not less than $1,000,000;

(d) an annual maximum benefit per person of not less than $250,000;

(e) the following deductibles:

(i) for the low deductible plans:

(A) $2,000 for an individual plan;

(B) $4,000 for a two party plan; and

(C) $6,000 for a family plan;

(ii) for the high deductible plans:

(A) $4,000 for an individual plan;

(B) $8,000 for a two party plan; and

(C) $12,000 for a family plan;

(f) the following out-of-pocket maximum costs, including deductibles, copayments, and coinsurance:

(i) for the low deductible plans:

(A) $5,000 for an individual plan;

(B) $10,000 for a two party plan; and

(C) $15,000 for a family plan; and

(ii) for the high deductible plan:

(A) $10,000 for an individual plan;

(B) $20,000 for a two party plan; and

(C) $30,000 for a family plan;

(g) the following benefits before applying any deductible requirements and in accordance with IRC Section 223:

(i) all well child exams and immunizations up to age five, with no annual maximum;

(ii) preventive care up to a $500 annual maximum;

(iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i) or (ii) up to a $300 annual maximum; and

(iv) supplemental accident coverage up to a $500 annual maximum;

(h) the following copayments for each exam:

(i) $15 for preventive care and well child exams;

(ii) $25 for primary care; and

(iii) $50 for urgent care and specialist care;

(i) a $200 copayment for emergency room visits after applying the deductible;

(j) no more than a 30% coinsurance after deductible for covered plan benefits for hospital services, maternity, laboratory work, x-rays, radiology, outpatient surgery services, injectable medications not otherwise covered under a pharmacy benefit, durable medical equipment, ambulance services, in-patient mental health services, and out-patient mental health services; and

(k) the following cost-sharing features for prescription drugs:

(i) up to a $15 copayment for generic drugs;

(ii) up to a 50% coinsurance for name brand drugs; and

(iii) may include formularies and preferred drug lists.

(3) The Utah NetCare Plans may exclude:

(a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and

(b) unless required by federal law, mandated coverage required by the following sections and related administrative rules:

(i) Section 31A-22-610.1, Adoption indemnity benefits;

(ii) Section 31A-22-623, Inborn metabolic errors;

(iii) Section 31A-22-624, Primary care physicians;

(iv) Section 31A-22-626, Coverage of diabetes;

(v) Section 31A-22-628, Standing referral to a specialist; and

(vi) except for the insurance coverage required in Section 31A-22-640, coverage mandates enacted after January 1, 2009, that are not required by federal law.

(4) (a) Beginning January 1, 2010, and except as provided in Subsection (5), a person may elect alternative coverage under this section if the person:

(i) is eligible for continuation of employer group coverage under federal COBRA laws;

(ii) is eligible for continuation of employer group coverage under state mini-COBRA under Section 31A-22-722; or

(iii) is eligible for a conversion to an individual plan after the exhaustion of benefits under:

(A) alternative coverage elected in place of federal COBRA; or

(B) state mini-COBRA under Section 31A-22-722.

(b) The right to extend coverage under Subsection (4)(a) applies to any spouse or dependent coverages, including a surviving spouse or dependent whose coverage under the policy terminates by reason of the death of the employee or member.

(5) If a person elects federal COBRA coverage, or state mini-COBRA coverage under Section 31A-22-722, the person is not eligible to elect alternative coverage under this section until the person is eligible to convert coverage to an individual policy under the provisions of Section 31A-22-723 and Subsection (1)(a).

(6) (a) If the alternative coverage is selected as an alternative to COBRA or mini-COBRA under Section 31A-22-722, the provisions of Section 31A-22-722 apply to the alternative coverage.

(b) If the alternative coverage is selected as a conversion policy under Section 31A-22-723, the provisions of Section 31A-22-723 apply.

(7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to September 1, 2009, file an alternative coverage policy with the department in accordance with Sections 31A-21-201 and 31A-21-201.1.

(b) The department shall, by November 1, 2009, adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to develop a model letter for employers to use to notify an employee of the employee's options for

alternative coverage.

Legislative Review Note
as of 1-7-11 10:14 AM

Office of Legislative Research and General Counsel