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INFERTILITY INSURANCE COVERAGE AMENDMENTS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Luz Escamilla

House Sponsor: _____

LONG TITLE

General Description:

This bill requires an insurer to offer the option of using the adoption indemnity benefit for infertility treatment.

Highlighted Provisions:

This bill:

- requires an insurer to offer the option of using the adoption indemnity benefit for infertility treatment; and
- requires an insurer to notify policyholders of this option.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-22-610.1, as last amended by Laws of Utah 2017, Chapter 292

31A-22-613.5, as last amended by Laws of Utah 2017, Chapters 241 and 292

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

Section 1. Section **31A-22-610.1** is amended to read:

31A-22-610.1. Indemnity benefit for adoption or infertility treatments.

S.B. 181

(1) (a) (i) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required.

(ii) This section does not prevent an accident and health insurer from:

(A) adjusting the benefit payable under this section for cost sharing measures imposed under the policy or contract for maternity benefit coverage; or

(B) providing additional adoption indemnity benefits including:

(I) extending the period of time after birth in which a child must be placed with an insured; or

(II) providing a benefit in excess of the amount specified in Subsection (1)(c).

(b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:

(i) the postplacement evaluation disapproves the adoption placement; and

(ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

(c) (i) The amount of the adoption indemnity benefit provided under Subsection (1) is $4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).

(ii) An insurer may comply with the provisions of this section by providing the $4,000 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining infertility treatments rather than seeking reimbursement for an adoption in accordance with terms designated by the insurer.

(iii) An insurer shall offer the adoption indemnity benefit option described in Subsection (1)(c)(ii) to all eligible enrollees.

(d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:

(i) has coverage for maternity benefits with a different insurer; and

(ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).

(2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:

(a) a child is placed for adoption with the insured within 90 days of the child's birth; and

(b) the adoption is finalized within one year of the child's birth.

(3) If an insured qualifies for the adoption indemnity benefit under this section and receives services from a network provider, the network provider may only collect from the insured the amount that the contracting health care provider is entitled to receive for such services under the contract, including any applicable copayment.

Section 2. Section **31A-22-613.5** is amended to read:

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

(1) (a) This section applies to all health benefit plans.

(b) Subsection (2) applies to:

(i) all health benefit plans; and

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

(2) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to provide to all enrollees, before enrollment in the health benefit plan, written disclosure of:

(a) restrictions or limitations on prescription drugs and biologics, including:

(i) the use of a formulary;

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

(iii) requirements for generic substitution;

(b) coverage limits under the plan;

(c) any limitation or exclusion of coverage, including:

(i) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

(ii) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition;

(d) [~~whether the insurer permits~~] the terms associated with an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) [~~and the terms associated with the exchange of benefits~~]; and

(e) whether the insurer provides coverage for telehealth services in accordance with

Section 26-18-13.5 and terms associated with that coverage.

(3) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to the commissioner:

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

(b) anytime the insurer amends any of the following described in Subsection (2):

(i) treatment policies;

(ii) practice standards;

(iii) restrictions;

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

(v) 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.

(4) (a) 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) 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.

(b) If under Subsection (2)(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.

(c) (i) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(c).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(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.

Legislative Review Note
Office of Legislative Research and General Counsel