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CHILDREN'S HEALTH INSURANCE PROGRAM AMENDMENTS

2015 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends the Utah Children's Health Insurance Program.

Highlighted Provisions:

This bill:

- amends membership provisions of the Utah Children's Health Insurance Program Advisory Council;
- deletes obsolete provisions;
- deletes a provision requiring the Department of Health to request bids for Utah Children's Health Insurance Program benefits at least once every five years;
- deletes provisions requiring the executive director of the Department of Health to consult with the Utah Children's Health Insurance Program Advisory Council under certain circumstances; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

H.B. 75

26-40-104, as last amended by Laws of Utah 2010, Chapter 286
26-40-106, as last amended by Laws of Utah 2012, Chapter 279
26-40-110, as last amended by Laws of Utah 2013, Chapter 103
26-40-115, as enacted by Laws of Utah 2011, Chapter 400
49-20-201, as last amended by Laws of Utah 2007, Chapter 130

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

Section 1. Section **26-40-104** is amended to read:

26-40-104. Utah Children's Health Insurance Program Advisory Council.

(1) There is created a Utah Children's Health Insurance Program Advisory Council consisting of at least [~~eight~~] five and no more than [~~11~~] eight members appointed by the executive director of the department. The term of each appointment shall be three years. The appointments shall be staggered at one-year intervals to ensure continuity of the advisory council.

(2) The advisory council shall meet at least quarterly.

(3) The membership of the advisory council shall include at least one representative from each of the following groups:

(a) child health care providers;

[~~(b) parents and guardians of children enrolled in the program;~~]

[~~(c)~~] (b) ethnic populations other than American Indians;

[~~(d)~~] (c) American Indians;

[~~(e) the Utah Association of Health Care Providers;~~]

[~~(f)~~] (d) health and accident and health insurance providers; and

[~~(g)~~] (e) the general public.

(4) The advisory council shall advise the department on:

(a) benefits design;

(b) eligibility criteria;

(c) outreach;

(d) evaluation; and

(e) special strategies for under-served populations.

(5) A member may not receive compensation or benefits for the member's service, but

may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Section 2. Section **26-40-106** is amended to read:

26-40-106. Program benefits.

[~~(1) Until the department implements a plan under Subsection (2), program benefits may include:~~]

[~~(a) hospital services;~~]

[~~(b) physician services;~~]

[~~(c) laboratory services;~~]

[~~(d) prescription drugs;~~]

[~~(e) mental health services;~~]

[~~(f) basic dental services;~~]

[~~(g) preventive care including:~~]

[~~(i) routine physical examinations;~~]

[~~(ii) immunizations;~~]

[~~(iii) basic vision services; and~~]

[~~(iv) basic hearing services;~~]

[~~(h) limited home health and durable medical equipment services; and~~]

[~~(i) hospice care.~~]

[~~(2) (a)~~] (1) Except as provided in Subsection [~~(2)(d), no later than July 1, 2008, the~~] (4), medical program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, to be actuarially equivalent to a health benefit plan with the largest insured commercial enrollment offered by a health maintenance organization in the state.

[~~(b)~~] (2) Except as provided in Subsection ([~~2)(d), after July 1, 2012~~] (4):

[~~(i)~~] (a) medical program benefits may not exceed the benefit level described in Subsection [~~(2)(a)~~] (1); and

[~~(ii)~~] (b) medical program benefits shall be adjusted every July 1[~~, thereafter~~] to meet the benefit level described in Subsection [~~(2)(a)~~] (1).

[~~(c)~~] (3) The dental benefit plan shall be benchmarked, in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the state, except that the utilization review mechanism for orthodontia shall be based on medical necessity. Dental program benefits shall be adjusted on July 1, 2012, and on July 1 every three years thereafter to meet the benefit level required by this Subsection [~~(2)(c)~~] (3).

[~~(d)~~] (4) The program benefits for enrollees who are at or below 100% of the federal poverty level are exempt from the benchmark requirements of Subsections [~~(2)(a)~~] (1) and (2)[~~(b)~~].

Section 3. Section **26-40-110** is amended to read:

26-40-110. Managed care -- Contracting for services.

(1) Program benefits provided to enrollees under the program, as described in Section 26-40-106, shall be delivered [~~in~~] by a managed care [~~system~~] organization if the department determines that adequate services are available where the enrollee lives or resides.

(2) [~~(a)~~] The department may contract with a managed care organization to provide program benefits. The department shall use the following criteria to evaluate [~~bids from health plans~~] a potential contract with a managed care organization:

(a) the managed care organization's:

(i) ability to manage medical expenses, including mental health costs;

(ii) proven ability to handle accident and health insurance;

(iii) efficiency of claim paying procedures;

(iv) proven ability for managed care and quality assurance;

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) [~~an estimate of~~] estimated total charges for administering the pool;

(viii) ability to administer the pool in a cost-efficient manner;

(ix) [~~the~~] ability to provide adequate providers and services in the state; and

[~~(x) for contracts entered into or renewed on or after January 1, 2014,~~]

(x) [~~the~~] ability to meet quality measures for emergency room use and access to primary care established by the department under Subsection 26-18-408(4); and

[~~(xi)~~] (b) other criteria established by the department.

[~~(b)~~] (3) The department may enter into separate contracts to provide dental benefits required by Section 26-40-106 [~~may be bid out separately from other program benefits~~].

[~~(c) Except for dental benefits, the department shall request bids for the program's benefits in 2008. The department shall request bids for the program's dental benefits in 2009. The department shall request bids for the program's benefits at least once every five years thereafter.~~]

[~~(d)~~] (4) The department's contract with a health [~~plans~~] or dental plan for the program's benefits shall include risk sharing provisions in which the [~~health~~] plan shall accept at least 75% of the risk for any difference between the department's premium payments per client and actual medical expenditures.

[~~(3) The executive director shall report to and seek recommendations from the Health Advisory Council created in Section 26-1-7.5:~~]

[~~(a) if the division receives less than two bids or proposals under this section that are acceptable to the division or responsive to the bid; and~~]

[~~(b) before awarding a contract to a managed care system.~~]

[~~(4) (a) The department shall award contracts to responsive bidders if the department determines that a bid is acceptable and meets the criteria of Subsections (2)(a) and (d).~~]

[~~(b)~~] (5) (a) The department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1) if[~~:~~] no other health or dental plan is willing to contract with the department or the department determines no other plan meets the criteria established under Subsection (2).

[~~(i) the executive director seeks the recommendation of the Health Advisory Council under Subsection (3); and~~]

[~~(ii) the executive director determines that the bids were not acceptable to the department.~~]

[~~(c)~~] (b) In accordance with Section 49-20-201, a contract awarded under Subsection [~~(4)(b)~~] (5)(a) is not subject to the risk sharing required by Subsection [~~(2)(d)~~] (4).

[~~(5) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.~~]

Section 4. Section **26-40-115** is amended to read:

26-40-115. State contractor -- Employee and dependent health benefit plan

coverage.

For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205, 63C-9-403, 72-6-107.5, and 79-2-404, "qualified health insurance coverage" means, at the time the contract is entered into or renewed:

(1) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the [~~Children's Health Insurance~~] program under Subsection 26-40-106[~~(2)(a)~~](1), and a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(a) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(b) for purposes of calculating actuarial equivalency under this Subsection (1)(b):

(i) rather [~~that~~] than the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(A) the deductible is $1,000 per individual and $3,000 per family; and

(B) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(ii) dental coverage is not required; and

(iii) other than Subsection 26-40-106[~~(2)(a)~~](1), the provisions of Section 26-40-106 do not apply; or

(2) a federally qualified high deductible health plan that, at a minimum:

(a) has a deductible that is either:

(i) the lowest deductible permitted for a federally qualified high deductible health plan; or

(ii) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(b) has an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(c) the employer pays 60% of the premium for the employee and the dependents of the

employee who work or reside in the state.

Section 5. Section **49-20-201** is amended to read:

49-20-201. Program participation -- Eligibility -- Optional for certain groups.

(1) (a) The state shall participate in the program on behalf of its employees.

(b) Other employers, including political subdivisions and educational institutions, are eligible, but are not required, to participate in the program on behalf of their employees.

(2) (a) [~~The~~] As provided in Subsection 26-40-110(5), the Department of Health may participate in the program for the purpose of providing health and dental benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act[~~, if the provisions in Subsection 26-40-110(4) occur~~].

(b) If the Department of Health participates in the program under the provisions of this Subsection (2), all insurance risk associated with the Utah Children's Health Insurance Program shall be the responsibility of the Department of Health and not the program or the office.

(3) A covered individual shall be eligible for coverage after termination of employment under rules adopted by the board.

(4) Only the following are eligible for Medicare supplement coverage under this chapter upon becoming eligible for Medicare Part A and Part B coverage:

(a) retirees;

(b) members;

(c) participants;

(d) employees who have medical employee benefit plan coverage at the time of their retirement; and

(e) current spouses of those who are eligible under Subsections (4)(a) through (d).

Legislative Review Note
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Office of Legislative Research and General Counsel