1 # HEALTH AMENDMENTS

2 2010 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: David Clark**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

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

11 **Highlighted Provisions:**

12 This bill:

13 ▸ requires accountability and transparency from the state Medicaid program;

14 ▸ requires an insurer to provide information to consumers regarding health insurance
15 policies; and

16 ▸ requires greater choice of benefit plans for employers in the defined contribution
17 market of the health insurance exchange.

18 **Monies Appropriated in this Bill:**

19 None

20 **Other Special Clauses:**

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

23 **Utah Code Sections Affected:**

24 AMENDS:

25 **26-18-2.3**, as last amended by Laws of Utah 2006, Chapter 46

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

27 **31A-22-613.5**, as last amended by Laws of Utah 2009, Chapter 12

H.B. 459

28 **31A-30-205**, as enacted by Laws of Utah 2009, Chapter 12

29 **Utah Code Sections Affected by Coordination Clause:**

30 **31A-22-613.5**, as last amended by Laws of Utah 2009, Chapter 12

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

32

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

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

35 **26-18-2.3. Division responsibilities -- Emphasis -- Periodic assessment.**

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

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

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

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

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

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

50 (b) preadmission certification of nonemergency admissions;

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

52 (d) second surgical opinions;

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

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

55 (g) coordination of benefits; and

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

59 (3) The director of the division shall periodically assess the cost effectiveness and
60 health implications of the existing Medicaid program, and consider alternative approaches to
61 the provision of covered health and medical services through the Medicaid program, in order to
62 reduce unnecessary or unreasonable utilization.
63 (4) The division shall ensure Medicaid program integrity by auditing the program for
64 fraud, waste, abuse, and cost recovery, at least in proportion to the percent of funding for the
65 program that comes from state funds.
66 (5) The division shall, by December 31 of each year, report to the Health and Human
67 Services Appropriations Subcommittee regarding:
68 (a) measures taken under this section to increase:
69 (i) efficiencies within the program; and
70 (ii) cost avoidance and cost recovery efforts in the program; and
71 (b) results of program integrity efforts under Subsection (4).
72 Section 2. Section **26-18-3** is amended to read:
73 **26-18-3. Administration of Medicaid program by department -- Reporting to the**
74 **Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility**
75 **standards.**
76 (1) The department shall be the single state agency responsible for the administration
77 of the Medicaid program in connection with the United States Department of Health and
78 Human Services pursuant to Title XIX of the Social Security Act.
79 (2) (a) The department shall implement the Medicaid program through administrative
80 rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking
81 Act, the requirements of Title XIX, and applicable federal regulations.
82 (b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules
83 necessary to implement the program:
84 (i) the standards used by the department for determining eligibility for Medicaid
85 services;
86 (ii) the services and benefits to be covered by the Medicaid program; and
87 (iii) reimbursement methodologies for providers under the Medicaid program.
88 (3) (a) The department shall, in accordance with Subsection (3)(b), report to either the
89 Legislative Executive Appropriations Committee or the Legislative Health and Human

90 Services Appropriations Subcommittee when the department:
91 (i) implements a change in the Medicaid State Plan;
92 (ii) initiates a new Medicaid waiver;
93 (iii) initiates an amendment to an existing Medicaid waiver; [~~or~~]
94 <u>(iv) applies for an extension of an application for a waiver or an existing Medicaid</u>
95 <u>waiver; or</u>
96 [~~(iv)~~] <u>(v)</u> initiates a rate change that requires public notice under state or federal law.
97 (b) The report required by Subsection (3)(a) shall:
98 (i) be submitted to the Legislature's Executive Appropriations Committee or the
99 legislative Health and Human Services Appropriations Subcommittee prior to the department
100 implementing the proposed change; and
101 (ii) [~~shall~~] include:
102 (A) a description of the department's current practice or policy that the department is
103 proposing to change;
104 (B) an explanation of why the department is proposing the change;
105 (C) the proposed change in services or reimbursement, including a description of the
106 effect of the change;
107 (D) the effect of an increase or decrease in services or benefits on individuals and
108 families;
109 (E) the degree to which any proposed cut may result in cost-shifting to more expensive
110 services in health or human service programs; and
111 (F) the fiscal impact of the proposed change, including:
112 (I) the effect of the proposed change on current or future appropriations from the
113 Legislature to the department;
114 (II) the effect the proposed change may have on federal matching dollars received by
115 the state Medicaid program;
116 (III) any cost shifting or cost savings within the department's budget that may result
117 from the proposed change; and
118 (IV) identification of the funds that will be used for the proposed change, including any
119 transfer of funds within the department's budget.
120 (4) Any rules adopted by the department under Subsection (2) are subject to review and

121 reauthorization by the Legislature in accordance with Section 63G-3-502.
122 (5) The department may, in its discretion, contract with the Department of Human
123 Services or other qualified agencies for services in connection with the administration of the
124 Medicaid program, including:
125 (a) the determination of the eligibility of individuals for the program;
126 (b) recovery of overpayments; and
127 (c) consistent with Section 26-20-13, and to the extent permitted by law and quality
128 control services, enforcement of fraud and abuse laws.
129 (6) The department shall provide, by rule, disciplinary measures and sanctions for
130 Medicaid providers who fail to comply with the rules and procedures of the program, provided
131 that sanctions imposed administratively may not extend beyond:
132 (a) termination from the program;
133 (b) recovery of claim reimbursements incorrectly paid; and
134 (c) those specified in Section 1919 of Title XIX of the federal Social Security Act.
135 (7) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX
136 of the federal Social Security Act shall be deposited in the General Fund as nonlapsing
137 dedicated credits to be used by the division in accordance with the requirements of Section
138 1919 of Title XIX of the federal Social Security Act.
139 (8) (a) In determining whether an applicant or recipient is eligible for a service or
140 benefit under this part or Chapter 40, Utah Children's Health Insurance Act, the department
141 shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle
142 designated by the applicant or recipient.
143 (b) Before Subsection (8)(a) may be applied:
144 (i) the federal government must:
145 (A) determine that Subsection (8)(a) may be implemented within the state's existing
146 public assistance-related waivers as of January 1, 1999;
147 (B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or
148 (C) determine that the state's waivers that permit dual eligibility determinations for
149 cash assistance and Medicaid are no longer valid; and
150 (ii) the department must determine that Subsection (8)(a) can be implemented within
151 existing funding.

152 (9) (a) For purposes of this Subsection (9):
153 (i) "aged, blind, or disabled" shall be defined by administrative rule; and
154 (ii) "spend down" means an amount of income in excess of the allowable income
155 standard that must be paid in cash to the department or incurred through the medical services
156 not paid by Medicaid.
157 (b) In determining whether an applicant or recipient who is aged, blind, or disabled is
158 eligible for a service or benefit under this chapter, the department shall use 100% of the federal
159 poverty level as:
160 (i) the allowable income standard for eligibility for services or benefits; and
161 (ii) the allowable income standard for eligibility as a result of spend down.
162 Section 3. Section **31A-22-613.5** is amended to read:
163 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**
164 **Care Plan.**
165 (1) (a) [~~Except as provided in Subsection (1)(b), this~~] This section applies to all health
166 [~~insurance policies and health maintenance organization contracts~~] benefit plans.
167 (b) Subsection (2) applies to:
168 (i) all [~~health insurance policies and health maintenance organization contracts~~] health
169 benefit plans; and
170 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
171 (2) (a) The commissioner shall promote informed consumer behavior and responsible
172 [~~health insurance and~~] health benefit plans by requiring an insurer issuing [~~health insurance~~
173 ~~policies or health maintenance organization contracts~~] a health benefit plan to:
174 (i) provide to all enrollees, prior to enrollment in the health benefit plan [~~or health~~
175 ~~insurance policy,~~] written disclosure of:
176 [~~(i)~~] (A) restrictions or limitations on prescription drugs and biologics including:
177 (I) the use of a formulary [~~and~~];
178 (II) co-payments and deductibles for prescription drugs; and
179 (III) requirements for generic substitution;
180 [~~(ii)~~] (B) coverage limits under the plan; and
181 [~~(iii)~~] (C) any limitation or exclusion of coverage including:
182 [~~(A)~~] (I) a limitation or exclusion for a secondary medical condition related to a

183 limitation or exclusion from coverage; and
184 [(B)] (II) [beginning July 1, 2009,] easily understood examples of a limitation or
185 exclusion of coverage for a secondary medical condition[.]; and
186 (ii) provide the commissioner with:
187 (A) the information described in Subsections 63M-1-2506(3) through (6) in the
188 standardized electronic format required by Subsection 63M-1-2506(1); and
189 (B) information regarding insurer transparency in accordance with Subsection (5).
190 (b) [In addition to the requirements of Subsections (2)(a), (d), and (e) an insurer
191 described in Subsection (2)(a) shall file the written] An insurer shall provide the disclosure
192 required by [this] Subsection (2)(a)(i) [to the commissioner:] in writing to the commissioner:
193 (i) upon commencement of operations in the state; and
194 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
195 (A) treatment policies;
196 (B) practice standards;
197 (C) restrictions;
198 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
199 (E) limitations or exclusions of coverage including a limitation or exclusion for a
200 secondary medical condition related to a limitation or exclusion of the insurer's health
201 insurance plan.
202 [(c) The commissioner may adopt rules to implement the disclosure requirements of
203 this Subsection (2), taking into account:]
204 [(i) business confidentiality of the insurer;]
205 [(ii) definitions of terms;]
206 [(iii) the method of disclosure to enrollees; and]
207 [(iv) limitations and exclusions.]
208 (c) An insurer shall provide the enrollee with notice of an increase in costs for
209 prescription drug coverage under Subsection (2)(a)(i)(A):
210 (i) either:
211 (A) in writing; or
212 (B) on the insurer's website; and
213 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as

214 soon as reasonably possible.
215 (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make
216 available to prospective enrollees and maintain evidence of the fact of the disclosure of:
217 (i) the drugs included;
218 (ii) the patented drugs not included;
219 (iii) any conditions that exist as a precedent to coverage; and
220 (iv) any exclusion from coverage for secondary medical conditions that may result
221 from the use of an excluded drug.
222 (e) (i) The department shall develop examples of limitations or exclusions of a
223 secondary medical condition that an insurer may use under Subsection (2)(a)[(iii)](i)(C).
224 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
225 (2)(a)[(iii)](i)(C) or otherwise are for illustrative purposes only, and the failure of a particular
226 fact situation to fall within the description of an example does not, by itself, support a finding
227 of coverage.
228 (3) An insurer who offers a health [care] benefit plan under Chapter 30, Individual,
229 Small Employer, and Group Health Insurance Act, shall[: (a) until January 1, 2010, offer the
230 basic health care plan described in Subsection (4) subject to the open enrollment provisions of
231 Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and (b) beginning
232 January 1, 2010,] offer a basic health care plan subject to the open enrollment provisions of
233 Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:
234 [(i)] (a) is a federally qualified high deductible health plan;
235 [(ii)] (b) has the lowest deductible that qualifies under a federally qualified high
236 deductible health plan, as adjusted by federal law; and
237 [(iii)] (c) does not exceed an annual out of pocket maximum equal to three times the
238 amount of the annual deductible.
239 [(4) Until January 1, 2010, the Basic Health Care Plan under this section shall provide
240 for:]
241 [(a) a lifetime maximum benefit per person not less than $1,000,000;]
242 [(b) an annual maximum benefit per person not less than $250,000;]
243 [(c) an out-of-pocket maximum of cost-sharing features:]
244 [(i) including:]

245 [~~(A) a deductible;~~]
246 [~~(B) a copayment; and~~]
247 [~~(C) coinsurance;~~]
248 [~~(ii) not to exceed $5,000 per person; and~~]
249 [~~(iii) for family coverage, not to exceed three times the per person out-of-pocket~~
250 ~~maximum provided in Subsection (4)(c)(ii);~~]
251 [~~(d) in relation to its cost-sharing features:~~]
252 [~~(i) a deductible of:~~]
253 [~~(A) not less than $1,000 per person for major medical expenses; and~~]
254 [~~(B) for family coverage, not to exceed three times the per person deductible for major~~
255 ~~medical expenses under Subsection (4)(d)(i)(A); and~~]
256 [~~(ii) (A) a copayment of not less than:~~]
257 [~~(I) $25 per visit for office services; and~~]
258 [~~(II) $150 per visit to an emergency room; or~~]
259 [~~(B) coinsurance of not less than:~~]
260 [~~(I) 20% per visit for office services; and~~]
261 [~~(II) 20% per visit for an emergency room; and~~]
262 [~~(e) in relation to cost-sharing features for prescription drugs:~~]
263 [~~(i) (A) a deductible not to exceed $1,000 per person; and~~]
264 [~~(B) for family coverage, not to exceed three times the per person deductible provided~~
265 ~~in Subsection (4)(e)(i)(A); and~~]
266 [~~(ii) (A) a copayment of not less than:~~]
267 [~~(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for~~
268 ~~prescription drugs;~~]
269 [~~(II) the lesser of the cost of the prescription drug or $25 for the second level of cost for~~
270 ~~prescription drugs; and~~]
271 [~~(III) the lesser of the cost of the prescription drug or $35 for the highest level of cost~~
272 ~~for prescription drugs; or~~]
273 [~~(B) coinsurance of not less than:~~]
274 [~~(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for~~
275 ~~prescription drugs;~~]

276 [~~(II) the lesser of the cost of the prescription drug or 40% for the second level of cost~~
277 ~~for prescription drugs; and~~]
278 [~~(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost~~
279 ~~for prescription drugs.~~]
280 [~~(5) The department shall include in its yearly insurance market report information~~
281 ~~about:~~]
282 [~~(a) the types of health benefit plans sold on the Internet portal created in Section~~
283 ~~63M-1-2504;~~]
284 [~~(b) the number of insurers participating in the defined contribution market on the~~
285 ~~Internet portal;~~]
286 [~~(c) the number of employers and covered lives in the defined contribution market;~~
287 ~~and~~]
288 [~~(d) the number of lives covered by health benefit plans that do not include state~~
289 ~~mandates as permitted by Subsection 31A-30-109(2).~~]
290 [~~(6)~~] (4) The commissioner:
291 (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to
292 the Health Insurance Exchange created under Section 63M-1-2504; and
293 (b) may request information from an insurer to verify the information submitted by the
294 insurer [~~to the Internet portal under Subsection 63M-1-2506(4)~~] under this section.
295 (5) The commissioner shall:
296 (a) convene a group of insurers, a member representing the Public Employees' Benefit
297 and Insurance Program, consumers, and an organization described in Subsection
298 31A-22-614.6(3)(b), to develop information for consumers to compare health insurers and
299 health benefit plans on the Health Insurance Exchange, which shall include consideration of:
300 (i) the number and cost of an insurer's denied health claims;
301 (ii) the cost of denied claims that is transferred to providers;
302 (iii) the average out-of-pocket expenses incurred by participants in each health benefit
303 plan that is offered by an insurer in the Health Insurance Exchange;
304 (iv) the relative efficiency and quality of claims administration and other administrative
305 processes for each insurer offering plans in the Health Insurance Exchange; and
306 (v) consumer assessment of each insurer or health benefit plan;

307 (b) adopt an administrative rule that establishes:
308 (i) definition of terms;
309 (ii) the methodology for determining and comparing the insurer transparency
310 information;
311 (iii) the data, and format of the data, that an insurer must submit to the department in
312 order to facilitate the consumer comparison on the Health Insurance Exchange in accordance
313 with Section 63M-1-2506; and
314 (iv) the dates on which the insurer must submit the data to the department in order for
315 the department to transmit the data to the Health Insurance Exchange in accordance with
316 Section 63M-1-2506; and
317 (c) implement the rules adopted under Subsection (5)(b) in a manner that protects the
318 business confidentiality of the insurer.
319 Section 4. Section **31A-30-205** is amended to read:
320 **31A-30-205. Health benefit plans offered in the defined contribution market.**
321 (1) An insurer who [~~chooses to offer a health benefit plan in the~~] offers a defined
322 contribution [~~market must~~] arrangement health benefit plan shall offer the following health
323 benefit plans as defined contribution arrangements:
324 [~~(a) one health benefit plan that:~~]
325 [~~(i) is a federally qualified high deductible health plan;~~]
326 [~~(ii) has the lowest deductible permitted for a federally qualified high deductible health~~
327 ~~plan as adjusted by federal law; and~~]
328 [~~(iii) does not exceed annual out-of-pocket maximum equal to three times the amount~~
329 ~~of the annual deductible; and~~]
330 (a) the basic benefit plan;
331 (b) one health benefit plan with [~~benefits that have~~] an aggregate actuarial value at least
332 15% greater [~~that~~] than the [~~plan described in Subsection (1)(a).~~] actuarial value of the basic
333 benefit plan;
334 (c) on or before January 1, 2011, one health benefit plan that is a federally qualified
335 high deductible health plan that has an individual deductible of $2,500 and a deductible of
336 $5,000 for coverage including two or more individuals, and has an out-of-pocket maximum
337 equal to the level of the deductible;

338 (d) on or before January 1, 2011, one health benefit plan that is a federally qualified
339 high deductible health plan that has the highest deductible that qualifies as a federally qualified
340 high deductible health plan as adjusted by federal law, and does not exceed an annual
341 out-of-pocket maximum equal to three times the amount of the annual deductible; and
342 (e) the insurer's five most commonly selected health benefit plans that:
343 (i) include:
344 (A) the provider panel;
345 (B) the deductible;
346 (C) co-payments;
347 (D) co-insurance; and
348 (E) pharmacy benefits; and
349 (ii) are currently being marketed by the carrier to new groups for enrollment.
350 (2) (a) The provisions of Subsection (1) do not limit the number of defined
351 contribution arrangement health benefit plans an insurer may offer in the defined contribution
352 arrangement market.
353 (b) An insurer who offers the health benefit plans required by Subsection (1) may also
354 offer any other health benefit plan [~~in the~~] as a defined contribution [~~market~~] arrangement if:
355 (i) the health benefit plan provides benefits that are [~~actuarially richer~~] of greater
356 actuarial value than the benefits required in [~~Subsection (1)(a).~~] the basic benefit plan; or
357 (ii) the health benefit plan provides benefits with an aggregate actuarial value that is no
358 lower than the actuarial value of the plan required in Subsection (1)(c).
359 Section 5. **Coordinating H.B. 459 with H.B. 294 -- Superseding amendments.**
360 If this H.B. 459 and H.B. 294, Health System Reform Amendments, both pass, it is the
361 intent of the Legislature that the amendments to Sections 31A-22-613.5 and 31A-30-205 in this
362 bill supersede the amendments to Sections 31A-22-613.5 and 31A-30-205 in H.B. 294, when
363 the Office of Legislative Research and General Counsel prepares the Utah Code database for
364 publication.

Legislative Review Note
as of 2-26-10 12:40 PM

Office of Legislative Research and General Counsel