1 **INSURANCE DEPARTMENT - HEALTH**
2 **INSURANCE REPORTING REQUIREMENTS**
3 2000 GENERAL SESSION
4 STATE OF UTAH
5 **Sponsor: Rebecca D. Lockhart**

6 AN ACT RELATING TO INSURANCE; AMENDING OR ELIMINATING CERTAIN
7 REPORTING REQUIREMENTS OF THE DEPARTMENT; ELIMINATING THE
8 REQUIREMENT THAT THE DEPARTMENT DEVELOP A BASIC INDIVIDUAL HEALTH
9 CARE PLAN; AND MAKING TECHNICAL AND CONFORMING AMENDMENTS.
10 This act affects sections of Utah Code Annotated 1953 as follows:
11 AMENDS:
12 **31A-22-613.5**, as last amended by Chapter 13, Laws of Utah 1998
13 **31A-30-110**, as last amended by Chapters 10 and 265, Laws of Utah 1997
14 *Be it enacted by the Legislature of the state of Utah:*
15 Section 1. Section **31A-22-613.5** is amended to read:
16 **31A-22-613.5. Price and value comparisons of health insurance.**
17 (1) This section applies generally to all health insurance policies and health maintenance
18 organization contracts.
19 (2) (a) Immediately after the effective date of this section, the commissioner shall appoint
20 a Health Benefit Plan Committee.
21 (b) The committee shall be composed of representatives of carriers, employers, employees,
22 health care providers, consumers, and producers, appointed to four-year terms.
23 (c) Notwithstanding the requirements of Subsection (2)(b), the commissioner shall, at the
24 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
25 committee members are staggered so that approximately half of the committee is appointed every
26 two years.
27 (3) When a vacancy occurs in the membership for any reason, the replacement shall be

28 appointed for the unexpired term.
29 (4) (a) Members shall receive no compensation or benefits for their services, but may
30 receive per diem and expenses incurred in the performance of the member's official duties at the
31 rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.
32 (b) Members may decline to receive per diem and expenses for their service.
33 (5) The committee shall serve as an advisory committee to the commissioner and shall
34 recommend services to be covered, copays, deductibles, levels of coinsurance, annual
35 out-of-pocket maximums, exclusions, and limitations for two or more designated health care plans
36 to be marketed in the state.
37 (a) The plans recommended by the committee may include reasonable benefit differentials
38 applicable to participating and nonparticipating providers.
39 (b) The plans recommended by the committee shall not prohibit the use of the following
40 cost management techniques by an insurer:
41 (i) preauthorization of health care services;
42 (ii) concurrent review of health care services;
43 (iii) case management of health care services;
44 (iv) retrospective review of medical appropriateness;
45 (v) selective contracting with hospitals, physicians, and other health care providers to the
46 extent permitted by law; and
47 (vi) other reasonable techniques intended to manage health care costs.
48 (c) The committee shall submit the plans to the commissioner within 180 days after the
49 appointment of the committee in accordance with this section.
50 (d) The commissioner shall adopt two or more health benefit plans within 60 days after
51 the committee submits recommendations.
52 (e) If the committee fails to submit recommendations to the commissioner within 180 days
53 after appointment, the commissioner shall, within 90 days, develop two or more designated health
54 benefit plans. The commissioner shall, after notice and hearing, adopt two or more designated
55 health benefit plans. The commissioner shall provide incentives for personal management of
56 health care expenses by adopting one plan that applies deductibles in the amount of $1,500 and
57 another plan that applies deductibles in the amount of $2,500. These plans may include
58 illustrations and explanations showing the premium savings generated by the high deductibles

59 being applied to a medical savings account for the insured which can be used to pay medical
60 expenses up to the plan deductible and/or any other medical expenses not covered by the insurance,
61 and an explanation that any funds in the savings account belong to the insured.
62 (f) The commissioner may reconvene a Health Benefit Plan Committee in accordance with
63 Subsections (2) and (5) to recommend revisions to the designated benefit plans adopted by the
64 commissioner.
65 (6) (a) Within 180 days after the adoption of the designated benefit plans by the
66 commissioner, or any changes in the designated plans an insurer offering health insurance policies
67 for sale in this state shall, at the request of a potential buyer, offer the current designated plans at
68 a premium based on factors such as that buyer's previous claims experience, group size,
69 demographic characteristics, and health status.
70 (b) This section does not prohibit an insurer from refusing to insure, under any plan, a
71 person or group. However, if the insurer offers any policy or contract to that person or group, the
72 insurer must offer the designated plans.
73 (7) The designated benefit plans, described in Subsection (5) are intended to facilitate price
74 and value comparisons by consumers. The designated benefit plans are not minimum standards
75 for health insurance policies. An insurer offering the designated benefit plans may offer policies
76 that provide more or less coverage than the designated benefit plans.
77 [~~(8) (a) The commissioner shall convene or reconvene a Health Benefit Plan Committee~~
78 ~~for the purpose of developing a Basic Health Care Plan to be offered under the open enrollment~~
79 ~~provisions of Chapter 30.~~]
80 [~~(b) The commissioner shall adopt a Basic Health Care Plan within 60 days after the~~
81 ~~committee submits recommendations, or if the committee fails to submit recommendations to the~~
82 ~~commissioner within 180 days after appointment, the commissioner shall, within 90 days, adopt~~
83 ~~a Basic Health Care Plan.~~]
84 [~~(c) (i) Before adoption of a plan under Subsection (8)(b), the commissioner shall submit~~
85 ~~the proposed Basic Health Care Plan to the Health and Human Services Interim Committee for~~
86 ~~review and recommendations.~~]
87 [~~(ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human~~
88 ~~Services Interim Committee shall provide legislative oversight of the Basic Health Care Plan and~~
89 ~~may recommend legislation to modify the Basic Health Care Plan adopted by the commissioner.~~]

90 [~~(d) The committee's recommendations for the Basic Health Care Plan shall be advisory~~
91 ~~to the commissioner.~~]
92 [~~(9) (a)~~] (8) (a) The commissioner shall promote informed consumer behavior and
93 responsible health insurance and health plans by requiring an insurer issuing health insurance
94 policies or health maintenance organization contracts to provide to all enrollees, prior to
95 enrollment in the health benefit plan or health insurance policy, written disclosure of:
96 (i) restrictions or limitations on prescription drugs and biologics including the use of a
97 formulary and generic substitution. If a formulary is used, the drugs included and the patented
98 drugs not included, and any conditions which exist as a precedent to coverage shall be made
99 readily available to prospective enrollees and evidence of the fact of that disclosure shall be
100 maintained by the insurer; and
101 (ii) coverage limits under the plan.
102 [~~(b) An insurer described in Subsection (9)(a) shall also submit the written disclosure~~
103 ~~required by this Subsection to the commissioner annually, and anytime thereafter when the insurer~~
104 ~~amends the treatment policies, practice standards, or restrictions described in Subsection (8)(a).~~]
105 [~~(c)~~] (b) The commissioner may adopt rules to implement the disclosure requirements of
106 this Subsection (8), taking into account business confidentiality of the insurer, definitions of terms,
107 and the method of disclosure to enrollees.
108 [~~(10) (a) The commissioner shall annually publish a table comparing the rates charged by~~
109 ~~insurers for the designated health plans and other health insurance plans in this state.~~]
110 [~~(b) The comparison shall list the top 20 insurers writing the greatest volume by premium~~
111 ~~dollar per calendar year and others requesting inclusion in the comparison.~~]
112 [~~(c) In conjunction with the rate comparison described in this subsection, the~~
113 ~~commissioner shall publish for each of the listed health insurers a table comparing the complaints~~
114 ~~filed and the combined loss and expense ratio as described in Subsections 31A-2-208.5(2) and (3).~~]
115 Section 2. Section **31A-30-110** is amended to read:
116 **31A-30-110. Individual enrollment cap.**
117 (1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.
118 (2) The commissioner shall raise the individual enrollment cap by .5% at the later of the
119 following dates:
120 (a) six months from the last increase in the individual enrollment cap; or

121 (b) the date when CCI/TI is greater than .90, where:
122 (i) "CCI" is the total individual coverage count for all carriers certifying that their
123 uninsurable percentage has reached the individual enrollment cap; and
124 (ii) "TI" is the total individual coverage count for all carriers.
125 (3) The commissioner may establish a minimum number of uninsurable individuals that
126 a carrier entering the market who is subject to this chapter must accept under the individual
127 enrollment provisions of this chapter.
128 (4) Beginning July 1, 1997, an individual carrier may decline to accept individuals
129 applying for individual enrollment under Subsection 31A-30-108(3), other than individuals
130 applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:
131 (a) the uninsurable percentage for that carrier equals or exceeds the cap established in
132 Subsection (1); and
133 (b) the covered carrier has certified on forms provided by the commissioner that its
134 uninsurable percentage equals or exceeds the individual enrollment cap.
135 (5) The department may audit a carrier's records to verify whether the carrier's uninsurable
136 classification meets industry standards for underwriting criteria as established by the commissioner
137 in accordance with Subsection 31A-30-106(1)(k).
138 (6) (a) On or before July 1, 1997, and each July 1 thereafter, the commissioner:
139 (i) shall report to the [~~Utah Health Policy Commission on~~] Health and Human Services
140 Interim Committee, upon request of the committee, regarding the distribution of risks assumed by
141 various carriers in the state under the individual enrollment provision of this part; and
142 (ii) may [~~make~~] offer recommendations to the [~~Utah Health Policy Commission and the~~
143 ~~Legislature~~] Health and Human Services Interim Committee regarding the adjustment of the .5%
144 cap on individual enrollment or some other risk adjustment to maintain equitable distribution of
145 risk among carriers.
146 (b) If the commissioner determines that individual enrollment is causing a substantial
147 adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or
148 delay further individual enrollment for up to 12 months.
149 (c) The commissioner shall adopt rules to establish a uniform methodology for calculating
150 and reporting loss ratios for individual policies for determining whether the individual enrollment
151 provisions of Section 31A-30-108 should be waived for an individual carrier experiencing

152 significant and adverse financial impact as a result of complying with those provisions.

153 [~~(7) (a) On or before November 30, 1995, the commissioner shall report to the Health~~

154 ~~Policy Commission and the Legislature on:~~]

155 [~~(i) the impact of the Small Employer Health Insurance Act on availability of small~~

156 ~~employer insurance in the market;~~]

157 [~~(ii) the number of carriers who have withdrawn from the market or ceased to issue new~~

158 ~~policies since the implementation of the Small Employer Health Insurance Act;~~]

159 [~~(iii) the expected impact of the individual enrollment provisions on the factors described~~

160 ~~in Subsections (7)(i) and (ii); and~~]

161 [~~(iv) the claims experience, costs, premiums, participation, and viability of the~~

162 ~~Comprehensive Health Insurance Pool created in Chapter 29.~~]

163 [~~(b) The report to the Legislature shall be submitted in writing to each legislator.~~]

Legislative Review Note
as of 1-20-00 3:19 PM

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel