

Representative Rebecca D. Lockhart proposes the following substitute bill:

HEALTH INSURANCE AMENDMENTS

2004 GENERAL SESSION

STATE OF UTAH

Sponsor: Rebecca D. Lockhart

LONG TITLE

General Description:

This bill makes technical and clarifying changes requested by the Department of Insurance and repeals and reenacts provisions regarding health insurance conversion rights.

Highlighted Provisions:

This bill:

- ▶ changes the date of the department's report to Health and Human Services;
- ▶ grants rulemaking authority to the commissioner to interpret and implement out-of-area dependent coverage;
- ▶ permits an insured to submit an adverse benefit determination to independent review in certain circumstances;
- ▶ requires a certificate of credible coverage for HIPAA compliance purposes;
- ▶ updates references to Operation Desert Storm to mobilization into the United States armed forces;
- ▶ changes the date on which a small employer carrier must file an actuarial certification from March 15 to April 1;
- ▶ enacts new sections regarding extension of employer group coverage and conversion coverage;
- ▶ repeals sections regarding:



- 26 • conversion rights on termination of coverage;
- 27 • conversion rules;
- 28 • provisions in conversion policies;
- 29 • conversion of health benefit plan;
- 30 • conversion privileges upon retirement;
- 31 • conversion privileges of spouse and child;
- 32 • conversion when benefits differ;
- 33 • converted policies delivered outside Utah; and
- 34 • extension of benefits; and
- 35 ▶ makes technical amendments.

36 Monies Appropriated in this Bill:

37 None

38 Other Special Clauses:

39 None

40 Utah Code Sections Affected:

41 AMENDS:

- 42 **31A-2-201**, as last amended by Chapter 277, Laws of Utah 2001
- 43 **31A-22-610.5**, as last amended by Chapters 116 and 207, Laws of Utah 2001
- 44 **31A-22-612**, as last amended by Chapter 116, Laws of Utah 2001
- 45 **31A-22-629**, as last amended by Chapter 42, Laws of Utah 2003
- 46 **31A-22-701**, as last amended by Chapter 116, Laws of Utah 2001
- 47 **31A-22-716**, as last amended by Chapter 116, Laws of Utah 2001
- 48 **31A-22-717**, as last amended by Chapter 116, Laws of Utah 2001
- 49 **31A-30-101**, as last amended by Chapter 308, Laws of Utah 2002
- 50 **31A-30-104**, as last amended by Chapter 298, Laws of Utah 2003
- 51 **31A-30-106**, as last amended by Chapter 252, Laws of Utah 2003

52 ENACTS:

- 53 **31A-22-722**, Utah Code Annotated 1953
- 54 **31A-22-723**, Utah Code Annotated 1953

55 REPEALS:

- 56 **31A-22-703**, as last amended by Chapters 250 and 308, Laws of Utah 2002

- 57 **31A-22-704**, as last amended by Chapter 116, Laws of Utah 2001
- 58 **31A-22-705**, as last amended by Chapter 308, Laws of Utah 2002
- 59 **31A-22-708**, as last amended by Chapter 308, Laws of Utah 2002
- 60 **31A-22-709**, as enacted by Chapter 242, Laws of Utah 1985
- 61 **31A-22-710**, as enacted by Chapter 242, Laws of Utah 1985
- 62 **31A-22-711**, as last amended by Chapter 329, Laws of Utah 1998
- 63 **31A-22-712**, as enacted by Chapter 242, Laws of Utah 1985
- 64 **31A-22-714**, as last amended by Chapter 308, Laws of Utah 2002

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

67 Section 1. Section **31A-2-201** is amended to read:

68 **31A-2-201. General duties and powers.**

69 (1) The commissioner shall administer and enforce this title.

70 (2) The commissioner has all powers specifically granted, and all further powers that
71 are reasonable and necessary to enable him to perform the duties imposed by this title.

72 (3) (a) The commissioner may make rules to implement the provisions of this title
73 according to the procedures and requirements of Title 63, Chapter 46a, Utah Administrative
74 Rulemaking Act.

75 (b) In addition to the notice requirements of Section 63-46a-4, the commissioner shall
76 provide notice under Section 31A-2-303 of hearings concerning insurance department rules.

77 (4) (a) The commissioner shall issue prohibitory, mandatory, and other orders as
78 necessary to secure compliance with this title. An order by the commissioner is not effective
79 unless the order:

80 (i) is in writing; and

81 (ii) is signed by the commissioner or under the commissioner's authority.

82 (b) On request of any person who would be affected by an order under Subsection
83 (4)(a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

84 (5) (a) The commissioner may hold informal adjudicative proceedings and public
85 meetings, for the purpose of investigation, ascertainment of public sentiment, or informing the
86 public.

87 (b) No effective rule or order may result from informal hearings and meetings unless

88 the requirement of a hearing under Section 31A-2-301 is satisfied.

89 (6) The commissioner shall inquire into violations of this title and may conduct any
90 examinations and investigations of insurance matters, in addition to examinations and
91 investigations expressly authorized, that he considers proper to determine:

92 (a) whether or not any person has violated any provision of this title; or

93 (b) to secure information useful in the lawful administration of any provision of this
94 title.

95 (7) (a) Each year, the commissioner shall:

96 (i) conduct an evaluation of the state's health insurance market;

97 (ii) report the findings of the evaluation to the Health and Human Services Interim
98 Committee before [~~July 31~~] October 1; and

99 (iii) publish the findings of the evaluation of the department website.

100 (b) The evaluation shall:

101 (i) analyze the effectiveness of the insurance regulations and statutes in promoting a
102 healthy, competitive health insurance market that meets the needs of Utahns by assessing such
103 things as the availability and marketing of individual and group products, rate charges,
104 coverage and demographic changes, benefit trends, market share changes, and accessibility;

105 (ii) assess complaint ratios and trends within the health insurance market, which
106 assessment shall integrate complaint data from the Office of Consumer Health Assistance
107 within the department;

108 (iii) contain recommendations for action to improve the overall effectiveness of the
109 health insurance market, administrative rules, and statutes; and

110 (iv) include claims loss ratio data for each insurance company doing business in the
111 state.

112 (c) When preparing the evaluation required by this section, the commissioner may seek
113 the input of insurers, employers, insured persons, providers, and others with an interest in the
114 health insurance market.

115 Section 2. Section **31A-22-610.5** is amended to read:

116 **31A-22-610.5. Dependent coverage.**

117 (1) As used in this section, "child" has the same meaning as defined in Section
118 78-45-2.

119 (2) (a) Any individual or group accident and health insurance policy or health
120 maintenance organization contract that provides coverage for a policyholder's or certificate
121 holder's dependent shall not terminate coverage of an unmarried dependent by reason of the
122 dependent's age before the dependent's 26th birthday and shall, upon application, provide
123 coverage for all unmarried dependents up to age 26.

124 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be
125 included in the premium on the same basis as other dependent coverage.

126 (c) This section does not prohibit the employer from requiring the employee to pay all
127 or part of the cost of coverage for unmarried dependents.

128 (3) An individual or group accident and health insurance policy or health maintenance
129 organization contract shall reinstate dependent coverage, and for purposes of all exclusions and
130 limitations, shall treat the dependent as if the coverage had been in force since it was
131 terminated; if:

132 (a) the dependent has not reached the age of 26 by July 1, 1995;

133 (b) the dependent had coverage prior to July 1, 1994;

134 (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age
135 of the dependent; and

136 (d) the policy has not been terminated since the dependent's coverage was terminated.

137 (4) (a) When a parent is required by a court or administrative order to provide health
138 insurance coverage for a child, an accident and health insurer may not deny enrollment of a
139 child under the accident and health insurance plan of the child's parent on the grounds the
140 child:

141 (i) was born out of wedlock and is entitled to coverage under Subsection (6);

142 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child
143 under the custodial parent's policy;

144 (iii) is not claimed as a dependent on the parent's federal tax return; or

145 (iv) does not reside with the parent or in the insurer's service area.

146 (b) An accident and health insurer providing enrollment under Subsection (4)(a)(iv) is
147 subject to the requirements of Subsection (5).

148 (5) A health maintenance organization or a preferred provider organization may use
149 alternative delivery systems or indemnity insurers to provide coverage under Subsection

150 (4)(a)(iv) outside its service area. Section 31A-8-408 does not apply to this Subsection (5).

151 (6) When a child has accident and health coverage through an insurer of a noncustodial
152 parent, and when requested by the noncustodial or custodial parent, the insurer shall:

153 (a) provide information to the custodial parent as necessary for the child to obtain
154 benefits through that coverage, but the insurer or employer, or the agents or employees of either
155 of them, are not civilly or criminally liable for providing information in compliance with this
156 Subsection (6)(a), whether the information is provided pursuant to a verbal or written request;

157 (b) permit the custodial parent or the service provider, with the custodial parent's
158 approval, to submit claims for covered services without the approval of the noncustodial
159 parent; and

160 (c) make payments on claims submitted in accordance with Subsection (6)(b) directly
161 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid
162 agency.

163 (7) When a parent is required by a court or administrative order to provide health
164 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

165 (a) permit the parent to enroll, under the family coverage, a child who is otherwise
166 eligible for the coverage without regard to an enrollment season restrictions;

167 (b) if the parent is enrolled but fails to make application to obtain coverage for the
168 child, enroll the child under family coverage upon application of the child's other parent, the
169 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.
170 651 through 669, the child support enforcement program; and

171 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate
172 coverage of the child unless the insurer is provided satisfactory written evidence that:

173 (A) the court or administrative order is no longer in effect; or

174 (B) the child is or will be enrolled in comparable accident and health coverage through
175 another insurer which will take effect not later than the effective date of disenrollment; or

176 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of
177 the child unless the employer is provided with satisfactory written evidence, which evidence is
178 also provided to the insurer, that Subsection (10)(c)(i), (ii) or (iii) has happened.

179 (8) An insurer may not impose requirements on a state agency that has been assigned
180 the rights of an individual eligible for medical assistance under Medicaid and covered for

181 accident and health benefits from the insurer that are different from requirements applicable to
182 an agent or assignee of any other individual so covered.

183 (9) Insurers may not reduce their coverage of pediatric vaccines below the benefit level
184 in effect on May 1, 1993.

185 (10) When a parent is required by a court or administrative order to provide health
186 coverage, which is available through an employer doing business in this state, the employer
187 shall:

188 (a) permit the parent to enroll under family coverage any child who is otherwise
189 eligible for coverage without regard to any enrollment season restrictions;

190 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
191 enroll the child under family coverage upon application by the child's other parent, by the state
192 agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651
193 through 669, the child support enforcement program;

194 (c) not disenroll or eliminate coverage of the child unless the employer is provided
195 satisfactory written evidence that:

196 (i) the court order is no longer in effect;

197 (ii) the child is or will be enrolled in comparable coverage which will take effect no
198 later than the effective date of disenrollment; or

199 (iii) the employer has eliminated family health coverage for all of its employees; and

200 (d) withhold from the employee's compensation the employee's share, if any, of
201 premiums for health coverage and to pay this amount to the insurer.

202 (11) An order issued under Section 62A-11-326.1 may be considered a "qualified
203 medical support order" for the purpose of enrolling a dependent child in a group accident and
204 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income
205 Security Act of 1974.

206 (12) This section does not affect any insurer's ability to require as a precondition of any
207 child being covered under any policy of insurance that:

208 (a) the parent continues to be eligible for coverage;

209 (b) the child shall be identified to the insurer with adequate information to comply with
210 this section; and

211 (c) the premium shall be paid when due.

212 (13) The provisions of this section apply to employee welfare benefit plans as defined
213 in Section 26-19-2.

214 (14) The commissioner shall adopt rules interpreting and implementing this section
215 with regard to out-of-area court ordered dependent coverage.

216 Section 3. Section **31A-22-612** is amended to read:

217 **31A-22-612. Conversion privileges for insured former spouse.**

218 (1) An accident and health insurance policy, which in addition to covering the insured
219 also provides coverage to the spouse of the insured, may not contain a provision for
220 termination of coverage of a spouse covered under the policy, except by entry of a valid decree
221 of divorce or annulment between the parties.

222 (2) Every policy which contains this type of provision shall provide that upon the entry
223 of the divorce decree the spouse is entitled to have issued an individual policy of accident and
224 health insurance without evidence of insurability, upon application to the company and
225 payment of the appropriate premium. The policy shall provide the coverage being issued
226 which is most nearly similar to the terminated coverage. Probationary or waiting periods in the
227 policy are considered satisfied to the extent the coverage was in force under the prior policy.

228 (3) When the insurer receives actual notice that the coverage of a spouse is to be
229 terminated because of a divorce or annulment, the insurer shall promptly provide the spouse
230 written notification of the right to obtain individual coverage as provided in Subsection (2), the
231 premium amounts required, and the manner, place, and time in which premiums may be paid.
232 The premium is determined in accordance with the insurer's table of premium rates applicable
233 to the age and class of risk of the persons to be covered and to the type and amount of coverage
234 provided. If the spouse applies and tenders the first monthly premium to the insurer within 30
235 days after receiving the notice provided by this subsection, the spouse shall receive individual
236 coverage that commences immediately upon termination of coverage under the insured's
237 policy.

238 (4) This section does not apply to accident and health insurance policies:

239 (a) offered on a group blanket basis[-]; or

240 (b) that comply with Section 31A-22-723.

241 Section 4. Section **31A-22-629** is amended to read:

242 **31A-22-629. Adverse benefit determination review process.**

- 243 (1) As used in this section:
- 244 (a) (i) "Adverse benefit determination" means the:
- 245 (A) denial of a benefit;
- 246 (B) reduction of a benefit;
- 247 (C) termination of a benefit; or
- 248 (D) failure to provide or make payment, in whole or in part, for a benefit.
- 249 (ii) "Adverse benefit determination" includes:
- 250 (A) denial, reduction, termination, or failure to provide or make payment that is based
- 251 on a determination of an insured's or a beneficiary's eligibility to participate in a plan;
- 252 (B) with respect to individual or group health plans, and income replacement or
- 253 disability income policies, a denial, reduction, or termination of, or a failure to provide or make
- 254 payment, in whole or in part, for, a benefit resulting from the application of a utilization
- 255 review; and
- 256 (C) failure to cover an item or service for which benefits are otherwise provided
- 257 because it is determined to be:
- 258 (I) experimental;
- 259 (II) investigational; or
- 260 (III) not medically necessary or appropriate.
- 261 (b) "Independent review" means a process that:
- 262 (i) is a voluntary option for the resolution of an adverse benefit determination;
- 263 (ii) is conducted at the discretion of the claimant;
- 264 (iii) is conducted by an independent review organization designated by the insurer;
- 265 (iv) renders an independent and impartial decision on an adverse benefit determination
- 266 submitted by an insured; and
- 267 (v) may not require the insured to pay a fee for requesting the independent review.
- 268 (c) "Insured" is as defined in Section 31A-1-301 and includes a person who is
- 269 authorized to act on the insured's behalf.
- 270 (d) "Insurer" is as defined in Section 31A-1-301 and includes:
- 271 (i) a health maintenance organization; and
- 272 (ii) a third-party administrator that offers, sells, manages, or administers a health
- 273 insurance policy or health maintenance organization contract that is subject to this title.

274 (e) "Internal review" means the process an insurer uses to review an insured's adverse
275 benefit determination before the adverse benefit determination is submitted for independent
276 review.

277 (2) This section applies generally to health insurance policies, health maintenance
278 organization contracts, and income replacement or disability income policies.

279 (3) (a) An insured may submit an adverse benefit determination to the insurer.

280 (b) The insurer shall conduct an internal review of the insured's adverse benefit
281 determination.

282 (c) An insured who disagrees with the results of an internal review may submit the
283 adverse benefit determination for an independent review if the adverse benefit determination
284 involves payment of a claim or denial of coverage regarding medical necessity.

285 (4) Before October 1, 2000, the commissioner shall adopt rules that establish minimum
286 standards for:

287 (a) internal reviews;

288 (b) independent reviews to ensure independence and impartiality;

289 (c) the types of adverse benefit determinations that may be submitted to an independent
290 review; and

291 (d) the timing of the review process, including an expedited review when medically
292 necessary.

293 (5) Nothing in this section may be construed as:

294 (a) expanding, extending, or modifying the terms of a policy or contract with respect to
295 benefits or coverage;

296 (b) permitting an insurer to charge an insured for the internal review of an adverse
297 benefit determination;

298 (c) restricting the use of arbitration in connection with or subsequent to an independent
299 review; or

300 (d) altering the legal rights of any party to seek court or other redress in connection
301 with:

302 (i) an adverse decision resulting from an independent review, except that if the insurer
303 is the party seeking legal redress, the insurer shall pay for the reasonable ~~attorneys~~ attorneys'
304 fees of the insured related to the action and court costs; or

305 (ii) an adverse benefit determination or other claim that is not eligible for submission
306 to independent review.

307 Section 5. Section **31A-22-701** is amended to read:

308 **31A-22-701. Groups eligible for group or blanket insurance.**

309 (1) A group or blanket accident and health insurance policy may be issued to:

310 (a) any group to which a group life insurance policy may be issued under Sections
311 31A-22-502 through 31A-22-507; or

312 [~~(b) a policy issued pursuant to a conversion privilege under Part VII; or~~]

313 [~~(c)~~] (b) a group specifically authorized by the commissioner under Section
314 31A-22-509, upon a finding that:

315 (i) authorization is not contrary to the public interest;

316 (ii) the proposed group is actuarially sound;

317 (iii) formation of the proposed group may result in economies of scale in
318 administrative, marketing, and brokerage costs; and

319 (iv) the health insurance policy, certificate, or other indicia of coverage that will be
320 offered to the proposed group is substantially equivalent to policies that are otherwise available
321 to similar groups.

322 (2) Blanket policies may also be issued to:

323 (a) any common carrier or any operator, owner, or lessee of a means of transportation,
324 as policyholder, covering persons who may become passengers as defined by reference to their
325 travel status;

326 (b) an employer, as policyholder, covering any group of employees, dependents, or
327 guests, as defined by reference to specified hazards incident to any activities of the
328 policyholder;

329 (c) an institution of learning, including a school district, school jurisdictional units, or
330 the head, principal, or governing board of any of those units, as policyholder, covering
331 students, teachers, or employees;

332 (d) any religious, charitable, recreational, educational, or civic organization, or branch
333 of those organizations, as policyholder, covering any group of members or participants as
334 defined by reference to specified hazards incident to the activities sponsored or supervised by
335 the policyholder;

336 (e) a sports team, camp, or sponsor of the team or camp, as policyholder, covering
337 members, campers, employees, officials, or supervisors;

338 (f) any volunteer fire department, first aid, civil defense, or other similar volunteer
339 organization, as policyholder, covering any group of members or participants as defined by
340 reference to specified hazards incident to activities sponsored, supervised, or participated in by
341 the policyholder;

342 (g) a newspaper or other publisher, as policyholder, covering its carriers;

343 (h) an association, including a labor union, which has a constitution and bylaws and
344 which has been organized in good faith for purposes other than that of obtaining insurance, as
345 policyholder, covering any group of members or participants as defined by reference to
346 specified hazards incident to the activities or operations sponsored or supervised by the
347 policyholder;

348 (i) a health insurance purchasing association organized and controlled solely by
349 participating employers as defined in Section 31A-34-103; and

350 (j) any other class of risks which, in the judgment of the commissioner, may be
351 properly eligible for blanket accident and health insurance.

352 (3) The judgment of the commissioner may be exercised on the basis of:

353 (a) individual risks;

354 (b) class of risks; or

355 (c) both Subsections (3)(a) and (b).

356 Section 6. Section **31A-22-716** is amended to read:

357 **31A-22-716. Required provision for notice of termination.**

358 (1) Every policy for group or blanket accident and health coverage issued or renewed
359 after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior
360 written notice of termination to each employee or group member and to notify each employee
361 or group member of his rights to continue coverage upon termination.

362 (2) An insurer's monthly notice to the policyholder of premium payments due shall
363 include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers
364 shall provide a sample notice to the policyholder at least once a year.

365 (3) For the purpose of compliance with federal law and the Health Insurance Portability
366 and Accountability Act, P.L. No. 104-191, 110 Stat. 1960, all health benefit plans, health

367 insurers, and student health plans must provide a certificate of creditable coverage to each
368 covered person upon their termination from the plan as soon as reasonably possible.

369 Section 7. Section **31A-22-717** is amended to read:

370 **31A-22-717. Provisions pertaining to service members and their families affected**
371 **by mobilization into the armed forces.**

372 For any group or blanket accident and health coverage, an insurer:

373 (1) may not refuse to reinstate an insured or his family whose coverage lapsed due to
374 the insured's [~~participation in Operation Desert Shield or Operation Desert Storm~~] mobilization
375 into the United States armed forces provided application is made within 180 days of release
376 from active duty;

377 (2) shall reinstate an insured in full upon payment of the first premium without the
378 requirement of a waiting period or exclusion for preexisting conditions or any other
379 underwriting requirements that were covered previously; and

380 (3) may not increase the insured's premium in excess of what it would have been
381 increased in the normal course of time had the insured not [~~participated in Operation Desert~~
382 ~~Shield or Operation Desert Storm~~] been mobilized into the United States armed forces.

383 Section 8. Section **31A-22-722** is enacted to read:

384 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

385 (1) An insured has the right to extend the employee's coverage under the group policy
386 for a period of six months, except as provided in Subsection (2). The right to extend coverage
387 includes:

388 (a) voluntary termination;

389 (b) involuntary termination;

390 (c) retirement;

391 (d) death;

392 (e) divorce or legal separation;

393 (f) loss of dependent status;

394 (g) sabbatical;

395 (h) any disability;

396 (i) leave of absence; or

397 (j) reduction of hours.

398 (2) (a) Notwithstanding the provisions of Subsection (1), an employee does not have
399 the right to extend coverage under the group policy if the employee:

400 (i) failed to pay any required individual contribution;

401 (ii) acquires other group coverage covering all preexisting conditions including
402 maternity, if the coverage exists;

403 (iii) performed an act or practice that constitutes fraud in connection with the coverage;

404 (iv) made an intentional misrepresentation of material fact under the terms of the
405 coverage;

406 (v) was terminated for gross misconduct; or

407 (vi) is eligible for any extension of coverage required by federal law.

408 (b) The right to extend coverage under Subsection (1) applies to any spouse or
409 dependent coverages, including a surviving spouse or dependents whose coverage under the
410 policy terminates by reason of the death of the employee or member.

411 (3) (a) The employer shall provide written notification of the right to extend group
412 coverage and the payment amounts required for extension of coverage, including the manner,
413 place, and time in which the payments shall be made to:

414 (i) the terminated insured;

415 (ii) the ex-spouse; or

416 (iii) if Subsection (2)(b) applies:

417 (A) to a surviving spouse; and

418 (B) the guardian of surviving dependents, if different from a surviving spouse.

419 (b) The notification shall be sent first class mail within 30 days after the termination
420 date of the group coverage to:

421 (i) the terminated insured's home address as shown on the records of the employer;

422 (ii) the address of the surviving spouse, if different from the insured's address and if
423 shown on the records of the employer;

424 (iii) the guardian of any dependents address, if different from the insured's address, and
425 if shown on the records of the employer; and

426 (iv) the address of the ex-spouse, if shown on the records of the employer.

427 (4) The insurer shall provide the employee, spouse, or any eligible dependent the
428 opportunity to extend the group coverage at the payment amount stated in this Subsection (3)

429 if:

430 (a) the employer policyholder does not provide the terminated insured the written
431 notification required by Subsection (3)(a); and

432 (b) the employee or other individual eligible for extension contacts the insurer within
433 60 days of coverage termination.

434 (5) The premium amount for extended group coverage may not exceed 102% of the
435 group rate in effect for a group member, including an employer's contribution, if any, for a
436 group insurance policy.

437 (6) Except as provided in this Subsection (6), the coverage extends without
438 interruption for six months and may not terminate if the terminated insured or, with respect to a
439 minor, the parent or guardian of the terminated insured:

440 (a) elects to extend group coverage within 60 days of losing group coverage; and

441 (b) tenders the amount required to the employer or insurer.

442 (7) The insured's coverage may be terminated prior to six months if the terminated
443 insured:

444 (a) establishes residence outside of this state;

445 (b) moves out of the insurer's service area;

446 (c) fails to pay premiums or contributions in accordance with the terms of the policy,
447 including any timeliness requirements;

448 (d) performs an act or practice that constitutes fraud in connection with the coverage;

449 (e) makes an intentional misrepresentation of material fact under the terms of the
450 coverage;

451 (f) becomes eligible for similar coverage under another group policy; or

452 (g) employer's coverage is terminated, except as provided in Subsection (8).

453 (8) If the employer coverage is terminated and the employer replaces coverage with
454 similar coverage under another group policy, without interruption, the terminated insured,
455 spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have
456 the right to obtain extension of coverage under the replacement group policy:

457 (a) for the balance of the period the terminated insured would have extended coverage
458 under the replaced group policy; and

459 (b) if the terminated insured is otherwise eligible for extension of coverage.

460 (9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the
461 employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of
462 the insured, the surviving spouse, or guardian of any dependents, written notification of the
463 right to an individual conversion policy.

464 (b) The notification required by Subsection (9)(a):

465 (i) shall be sent first class mail to:

466 (A) the insured's last-known address as shown on the records of the employer;

467 (B) the address of the surviving spouse, if different from the insured's address, and if
468 shown on the records of the employer;

469 (C) the guardian of any dependents last known address as shown on the records of the
470 employer, if different from the address of the surviving spouse; and

471 (D) the address of the ex-spouse as shown on the records of the employer, if
472 applicable; and

473 (ii) shall contain the name, address, and telephone number of the insurer that will
474 provide the conversion coverage.

475 Section 9. Section **31A-22-723** is enacted to read:

476 **31A-22-723. Group and blanket conversion coverage.**

477 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection
478 (3), all policies of accident and health insurance offered on a group basis under this title, or
479 Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that
480 a person whose insurance under the group policy has been terminated is entitled to choose a
481 converted individual policy of similar accident and health insurance.

482 (2) A person who has lost group coverage may elect conversion coverage with the
483 insurer that provided prior group coverage if the person:

484 (a) has been continuously covered under a group policy for a period of six months
485 immediately prior to termination; and

486 (b) has exhausted either Utah mini-COBRA coverage as required in Section
487 31A-22-722 or federal COBRA coverage, if offered; and

488 (c) has not acquired or is not covered under any other group coverage that covers all
489 preexisting conditions including maternity, if the coverage exists.

490 (3) This section does not apply if the person's prior group coverage:

- 491 (a) is a stand alone policy that only provides one of the following:
492 (i) catastrophic benefits;
493 (ii) aggregate stop loss benefits;
494 (iii) specific stop loss benefits;
495 (iv) benefits for specific diseases;
496 (v) accidental injuries only;
497 (vi) dental; or
498 (vii) vision;
499 (b) is an income replacement policy; or
500 (c) was terminated because the insured:
501 (i) failed to pay any required individual contribution;
502 (ii) performed an act or practice that constitutes fraud in connection with the coverage;
503 or
504 (iii) made intentional misrepresentation of material fact under the terms of coverage.
505 (4) (a) The employer shall provide written notification of the right to an individual
506 conversion policy within 30 days of the insured's termination of coverage to:
507 (i) the terminated insured;
508 (ii) the ex-spouse; or
509 (iii) in the case of the death of the insured:
510 (A) the surviving spouse; or
511 (B) the guardian of any dependents, if different from a surviving spouse.
512 (b) The notification required by Subsection (4)(a) shall:
513 (i) be sent by first class mail;
514 (ii) contain the name, address, and telephone number of the insurer that will provide
515 the conversion coverage; and
516 (iii) be sent to the insured's last-known address as shown on the records of the
517 employer of:
518 (A) the insured;
519 (B) the ex-spouse; and
520 (C) if the policy terminates by reason of the death of the insured to:
521 (I) the surviving spouse; or

- 522 (II) the guardian of any dependents if different from a surviving spouse.
- 523 (5) (a) An insurer is not required to issue a converted policy which provides benefits in
524 excess of those provided under the group policy from which conversion is made.
- 525 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health
526 benefit plan, the employee or member must be offered at least the basic benefit plan as
527 provided in Subsection 31A-22-613.5(2)(a).
- 528 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels
529 provided under the group policy, the conversion policy may offer benefits which are
530 substantially similar to those provided under the group policy.
- 531 (6) Written application for the converted policy shall be made and the first premium
532 paid to the insurer no later than 60 days after termination of the group accident and health
533 insurance.
- 534 (7) The converted policy shall be issued without evidence of insurability.
- 535 (8) (a) The initial premium for the converted policy for the first 12 months and
536 subsequent renewal premiums shall be determined in accordance with premium rates
537 applicable to age, class of risk of the person, and the type and amount of insurance provided.
- 538 (b) The initial premium for the first 12 months may not be raised based on pregnancy
539 of a covered insured.
- 540 (c) The premium for converted policies shall be payable monthly or quarterly as
541 required by the insurer for the policy form and plan selected, unless another mode or premium
542 payment is mutually agreed upon.
- 543 (9) The converted policy becomes effective at the time the insurance under the group
544 policy terminates.
- 545 (10) (a) A newly issued converted policy covers the employee or the member and must
546 also cover all dependents covered by the group policy at the date of termination of the group
547 coverage.
- 548 (b) The only dependents that may be added after the policy has been issued are children
549 and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).
- 550 (c) At the option of the insurer, a separate converted policy may be issued to cover any
551 dependent.
- 552 (11) (a) To the extent the group policy provided maternity benefits, the conversion

553 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group
554 policy or the conversion policy until termination of a pregnancy that exists on the date of
555 conversion if one of the following is pregnant on the date of the conversion:

- 556 (i) the insured;
557 (ii) a spouse of the insured; or
558 (iii) a dependent of the insured.

559 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs
560 after the date of conversion.

561 (12) Except as provided in this Subsection (12), a converted policy is renewable with
562 respect to all individuals or dependents at the option of the insured. An insured may be
563 terminated from a converted policy for the following reasons:

- 564 (a) a dependent is no longer eligible under the policy;
565 (b) for a network plan, if the individual no longer lives, resides, or works in:
566 (i) the insured's service area; or
567 (ii) the area for which the covered carrier is authorized to do business; or
568 (c) the individual fails to pay premiums or contributions in accordance with the terms
569 of the converted policy, including any timeliness requirements;
570 (d) the individual performs an act or practice that constitutes fraud in connection with
571 the coverage;
572 (e) the individual makes an intentional misrepresentation of material fact under the
573 terms of the coverage; or
574 (f) coverage is terminated uniformly without regard to any health status-related factor
575 relating to any covered individual.

576 (13) Conditions pertaining to health may not be used as a basis for classification under
577 this section.

578 Section 10. Section **31A-30-101** is amended to read:

579 **31A-30-101. Title.**

580 This chapter is known as the "Individual, Small Employer, and Group [Employer]
581 Health Insurance Act."

582 Section 11. Section **31A-30-104** is amended to read:

583 **31A-30-104. Applicability and scope.**

- 584 (1) This chapter applies to any:
- 585 (a) health benefit plan that provides coverage to:
- 586 (i) individuals;
- 587 (ii) small employers; or
- 588 (iii) both Subsections (1)(a)(i) and (ii); or
- 589 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
- 590 31A-30-107.5.
- 591 (2) This chapter applies to a health benefit plan that provides coverage to small
- 592 employers or individuals regardless of:
- 593 (a) whether the contract is issued to:
- 594 (i) an association;
- 595 (ii) a trust;
- 596 (iii) a discretionary group; or
- 597 (iv) other similar grouping; or
- 598 (b) the situs of delivery of the policy or contract.
- 599 (3) This chapter does not apply to:
- 600 (a) a large employer health benefit plan; ~~[or]~~
- 601 (b) short-term limited duration health insurance~~[-];~~ or
- 602 (c) federally funded or partially funded programs.
- 603 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:
- 604 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
- 605 return shall be treated as one carrier; and
- 606 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
- 607 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
- 608 carriers were issued by one carrier.
- 609 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
- 610 maintenance organization having a certificate of authority under this title may be considered to
- 611 be a separate carrier for the purposes of this chapter.
- 612 (c) Unless otherwise authorized by the commissioner, a covered carrier may not enter
- 613 into one or more ceding arrangements with respect to health benefit plans delivered or issued
- 614 for delivery to covered insureds in this state if the ceding arrangements would result in less

615 than 50% of the insurance obligation or risk for the health benefit plans being retained by the
616 ceding carrier.

617 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
618 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
619 for delivery to covered insureds in this state.

620 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
621 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
622 may make a written request to the commissioner for a waiver from the application of any of the
623 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
624 trust.

625 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
626 waiver if the commissioner finds that application with respect to the trust would:

627 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
628 and

629 (ii) require significant modifications to one or more collective bargaining arrangements
630 under which the trust is established or maintained.

631 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
632 person participates in a Taft Hartley trust as an associate member of any employee
633 organization.

634 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
635 31A-30-111 apply to:

636 (a) any insurer engaging in the business of insurance related to the risk of a small
637 employer for medical, surgical, hospital, or ancillary health care expenses of the small
638 employer's employees provided as an employee benefit; and

639 (b) any contract of an insurer, other than a workers' compensation policy, related to the
640 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
641 small employer's employees provided as an employee benefit.

642 (7) The commissioner may make rules requiring that the marketing practices be
643 consistent with this chapter for:

644 (a) a small employer carrier;

645 (b) a small employer carrier's agent;

646 (c) an insurance producer; and

647 (d) an insurance consultant.

648 Section 12. Section **31A-30-106** is amended to read:

649 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**

650 (1) Premium rates for health benefit plans under this chapter are subject to the
651 provisions of this Subsection (1).

652 (a) The index rate for a rating period for any class of business may not exceed the
653 index rate for any other class of business by more than 20%.

654 (b) (i) For a class of business, the premium rates charged during a rating period to
655 covered insureds with similar case characteristics for the same or similar coverage, or the rates
656 that could be charged to such employers under the rating system for that class of business, may
657 not vary from the index rate by more than 30% of the index rate, except as provided in Section
658 31A-22-625.

659 (ii) A covered carrier that offers individual and small employer health benefit plans
660 may use the small employer index rates to establish the rate limitations for individual policies,
661 even if some individual policies are rated below the small employer base rate.

662 (c) The percentage increase in the premium rate charged to a covered insured for a new
663 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
664 the following:

665 (i) the percentage change in the new business premium rate measured from the first day
666 of the prior rating period to the first day of the new rating period;

667 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
668 of less than one year, due to the claim experience, health status, or duration of coverage of the
669 covered individuals as determined from the covered carrier's rate manual for the class of
670 business, except as provided in Section 31A-22-625; and

671 (iii) any adjustment due to change in coverage or change in the case characteristics of
672 the covered insured as determined from the covered carrier's rate manual for the class of
673 business.

674 (d) (i) Adjustments in rates for claims experience, health status, and duration from
675 issue may not be charged to individual employees or dependents.

676 (ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the

677 rates charged for all employees and dependents of the small employer.

678 (e) A covered carrier may use industry as a case characteristic in establishing premium
679 rates, provided that the highest rate factor associated with any industry classification does not
680 exceed the lowest rate factor associated with any industry classification by more than 15%.

681 (f) (i) Covered carriers shall apply rating factors, including case characteristics,
682 consistently with respect to all covered insureds in a class of business.

683 (ii) Rating factors shall produce premiums for identical groups that:

684 (A) differ only by the amounts attributable to plan design; and

685 (B) do not reflect differences due to the nature of the groups assumed to select
686 particular health benefit products.

687 (iii) A covered carrier shall treat all health benefit plans issued or renewed in the same
688 calendar month as having the same rating period.

689 (g) For the purposes of this Subsection (1), a health benefit plan that uses a restricted
690 network provision may not be considered similar coverage to a health benefit plan that does not
691 use such a network, provided that use of the restricted network provision results in substantial
692 difference in claims costs.

693 (h) The covered carrier may not, without prior approval of the commissioner, use case
694 characteristics other than:

695 (i) age;

696 (ii) gender;

697 (iii) industry;

698 (iv) geographic area;

699 (v) family composition; and

700 (vi) group size.

701 (i) (i) The commissioner may establish rules in accordance with Title 63, Chapter 46a,
702 Utah Administrative Rulemaking Act, to:

703 (A) implement this chapter; and

704 (B) assure that rating practices used by covered carriers are consistent with the
705 purposes of this chapter.

706 (ii) The rules described in Subsection (1)(i)(i) may include rules that:

707 (A) assure that differences in rates charged for health benefit products by covered

708 carriers are reasonable and reflect objective differences in plan design, not including
709 differences due to the nature of the groups assumed to select particular health benefit products;
710 (B) prescribe the manner in which case characteristics may be used by covered carriers;
711 (C) implement the individual enrollment cap under Section 31A-30-110, including
712 specifying:
713 (I) the contents for certification;
714 (II) auditing standards;
715 (III) underwriting criteria for uninsurable classification; and
716 (IV) limitations on high risk enrollees under Section 31A-30-111; and
717 (D) establish the individual enrollment cap under Subsection 31A-30-110(1).
718 (j) Before implementing regulations for underwriting criteria for uninsurable
719 classification, the commissioner shall contract with an independent consulting organization to
720 develop industry-wide underwriting criteria for uninsurability based on an individual's expected
721 claims under open enrollment coverage exceeding 200% of that expected for a standard
722 insurable individual with the same case characteristics.
723 (k) The commissioner shall revise rules issued for Sections 31A-22-602 and
724 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance
725 with this section.
726 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit
727 product into which the covered carrier is no longer enrolling new covered insureds, the covered
728 carrier shall use the percentage change in the base premium rate, provided that the change does
729 not exceed, on a percentage basis, the change in the new business premium rate for the most
730 similar health benefit product into which the covered carrier is actively enrolling new covered
731 insureds.
732 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
733 a class of business.
734 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
735 of business unless the offer is made to transfer all covered insureds in the class of business
736 without regard:
737 (i) to case characteristics;
738 (ii) claim experience;

739 (iii) health status; or

740 (iv) duration of coverage since issue.

741 (4) (a) Each covered carrier shall maintain at the covered carrier's principal place of
742 business a complete and detailed description of its rating practices and renewal underwriting
743 practices, including information and documentation that demonstrate that the covered carrier's
744 rating methods and practices are:

745 (i) based upon commonly accepted actuarial assumptions; and

746 (ii) in accordance with sound actuarial principles.

747 (b) (i) Each covered carrier shall file with the commissioner, on or before [~~March 15~~]
748 April 1 of each year, in a form, manner, and containing such information as prescribed by the
749 commissioner, an actuarial certification certifying that:

750 (A) the covered carrier is in compliance with this chapter; and

751 (B) the rating methods of the covered carrier are actuarially sound.

752 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the
753 covered carrier at the covered carrier's principal place of business.

754 (c) A covered carrier shall make the information and documentation described in this
755 Subsection (4) available to the commissioner upon request.

756 (d) Records submitted to the commissioner under this section shall be maintained by
757 the commissioner as protected records under Title 63, Chapter 2, Government Records Access
758 and Management Act.

759 **Section 13. Repealer.**

760 This bill repeals:

761 **Section 31A-22-703, Conversion rights on termination of group accident and**
762 **health insurance coverage.**

763 **Section 31A-22-704, Conversion rules and procedures.**

764 **Section 31A-22-705, Provisions in conversion policies.**

765 **Section 31A-22-708, Conversion of health benefit plan.**

766 **Section 31A-22-709, Conversion privilege upon retirement.**

767 **Section 31A-22-710, Conversion privilege of spouse and children.**

768 **Section 31A-22-711, If conversion plan benefits exceed group policy benefits.**

769 **Section 31A-22-712, Converted policies delivered outside Utah.**

770

Section 31A-22-714, Extension of benefits.