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H.B. 188
2nd Sub. (Gray)

Senator Gregory S. Bell proposes the following substitute bill:

HEALTH SYSTEM REFORM - INSURANCE MARKET

2009 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: David Clark

Senate Sponsor: Gregory S. Bell

Cosponsors:
Roger E. Barrus
Ron Bigelow
Bradley M. Daw
Brad L. Dee
Ben C. Ferry
Kevin S. Garn
Bradley G. Last
David Litvack
Merlynn T. Newbold
Patrick Painter

LONG TITLE

General Description:

This bill amends the Insurance Code and the Governor's Office of Economic Development Code to expand access to the health insurance market, increase market flexibility, and provide greater transparency in the health insurance market.

Highlighted Provisions:

This bill:

- prohibits balanced billing by certain health care providers in certain circumstances;
- revises the basic benefit plan used for consumer comparison of health benefit products;
- requires the Insurance Department to include in its annual market report a summary of the types of plans sold through the Internet portal, including market penetration of mandate lite products;
- allows insurers to offer lower cost health insurance products that do not include certain state mandates in the individual market, the small employer group market,

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and in the conversion market;

- creates the Utah NetCare Plan, a low cost health benefit plan as an alternative to current federal COBRA, state mini-COBRA, and conversion products;
- requires health insurance brokers and producers to disclose their commissions and compensation to their customers prior to selling a health benefit plan;
- modifies the number and type of products an insurer must offer in the small employer group market and the individual market;
- establishes a defined contribution arrangement market available on the Internet portal, which:
  - beginning January 1, 2010 is available to small employer groups;
  - offers a range of health benefit plan choices to an employer's eligible employees;
  - beginning January 1, 2012, is available to eligible large employer groups; and
  - beginning January 1, 2012, will offer a wider range of choices of health benefit plans to employees;
- establishes a board within the Insurance Department that is given the responsibility to develop a risk adjustment mechanism that will apportion risk among the insurers participating in the Internet portal defined contribution market to protect insurers from adverse risk selection;
- requires insurers who offer health benefit plans on the Internet portal to provide greater transparency and disclose information about the plan benefits, provider networks, wellness programs, claim payment practices, and solvency ratings;
- establishes a process for a consumer to compare health plan features on the Internet portal and to enroll in a health benefit plan from the Internet portal;
- requires the Office of Consumer Health Services to convene insurers and health care providers to monitor and report to the Health Reform Task Force and to the Business and Labor Interim Committee regarding progress towards expanding access to the defined contribution market, greater choice in the market, and payment reform demonstration projects;
- establishes limited rulemaking authority for the Office of Consumer Health Services to:

- assist employers and insurance carriers with interacting with the Internet portal; and
- facilitate the receipt and payment of health plan premium payments from multiple sources;

▸ authorizes the Office of Consumer Health Services to establish a fee to cover the transaction cost associated with the Internet portal functions such as sending and processing an application or processing multiple premium payment sources; and

▸ re-authorizes the Health Reform Task Force for one year.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill provides an immediate effective date.

This bill repeals the Health Reform Task Force on December 30, 2009.

Utah Code Sections Affected:

AMENDS:

31A-8-501, as last amended by Laws of Utah 2004, Chapters 90, 229, and 367

31A-22-613.5, as last amended by Laws of Utah 2008, Chapters 241 and 345

31A-22-617, as last amended by Laws of Utah 2008, Chapter 3

31A-22-722, as last amended by Laws of Utah 2006, Chapter 188

31A-22-723, as last amended by Laws of Utah 2008, Chapters 241 and 250

31A-23a-401, as last amended by Laws of Utah 2007, Chapter 307

31A-23a-501, as renumbered and amended by Laws of Utah 2003, Chapter 298

31A-30-102, as last amended by Laws of Utah 2008, Chapter 345

31A-30-103, as last amended by Laws of Utah 2007, Chapter 307

31A-30-104, as last amended by Laws of Utah 2004, Chapter 108

31A-30-107, as last amended by Laws of Utah 2004, Chapter 329

31A-30-109, as last amended by Laws of Utah 1997, Chapter 265

31A-30-112, as last amended by Laws of Utah 2008, Chapter 345

63M-1-2504, as enacted by Laws of Utah 2008, Chapter 383

ENACTS:

31A-22-618.5, Utah Code Annotated 1953

31A-22-724, Utah Code Annotated 1953
31A-30-201, Utah Code Annotated 1953
31A-30-202, Utah Code Annotated 1953
31A-30-203, Utah Code Annotated 1953
31A-30-204, Utah Code Annotated 1953
31A-30-205, Utah Code Annotated 1953
31A-30-206, Utah Code Annotated 1953
31A-30-207, Utah Code Annotated 1953
31A-30-208, Utah Code Annotated 1953
31A-42-101, Utah Code Annotated 1953
31A-42-102, Utah Code Annotated 1953
31A-42-103, Utah Code Annotated 1953
31A-42-201, Utah Code Annotated 1953
31A-42-202, Utah Code Annotated 1953
31A-42-203, Utah Code Annotated 1953
31A-42-204, Utah Code Annotated 1953
63M-1-2506, Utah Code Annotated 1953

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

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

Section 1. Section **31A-8-501** is amended to read:

31A-8-501. Access to health care providers.

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a health maintenance organization

contract.

(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.

(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.

(e) "Independent hospital" means a general acute hospital or a critical access hospital that:

(i) is either:

(A) located 20 miles or more from any other general acute hospital or critical access hospital; or

(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located and:

(A) the board of directors is ultimately responsible for the policy and financial decisions of the hospital; or

(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member who has not contracted with a health maintenance organization to provide health care services to enrollees of the organization.

(2) Except for a health maintenance organization which is under the common ownership or control of an entity with a hospital located within ten paved road miles of an independent hospital, a health maintenance organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the independent hospital; or

(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the

independent hospital than a contracting hospital;

(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(3) A health maintenance organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the federally qualified health center; or

(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;

(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(4) (a) A health maintenance organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement for comparable services.

(b) A health maintenance organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the health maintenance organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.

(5) (a) A noncontracting independent hospital may not balance bill a patient when the health maintenance organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a).

(b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

[~~(5)~~] (6) A noncontracting provider may only refer an enrollee to another noncontracting provider so as to obligate the enrollee's health maintenance organization to pay for the resulting services if:

(a) the noncontracting provider making the referral or the enrollee has received prior authorization from the organization for the referral; or

(b) the practice location of the noncontracting provider to whom the referral is made:

(i) is located in a county with a population density of less than 25 people per square mile; and

(ii) is within 30 paved road miles of:

(A) the place where the enrollee lives or resides; or

(B) the independent hospital or federally qualified health center at which the enrollee may receive covered services pursuant to Subsection (2) or (3).

[~~(6)~~] (7) Notwithstanding this section, a health maintenance organization may contract directly with an independent hospital, federally qualified health center, or credentialed staff member.

[~~(7)~~] (8) (a) A health maintenance organization that violates any provision of this section is subject to sanctions as determined by the commissioner in accordance with Section 31A-2-308.

(b) Violations of this section include:

(i) failing to provide the notice required by Subsection [~~(7)~~] (8)(d) by placing the notice in any health maintenance organization's provider list that is supplied to enrollees, including any website maintained by the health maintenance organization;

(ii) failing to provide notice of an enrolles's rights under this section when:

(A) an enrollee makes personal contact with the health maintenance organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about his rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the health maintenance organization, when the provisions of this section apply to the claim.

(c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner:

(i) adopt rules as necessary to implement this section;

(ii) identify in rule:

(A) the counties with a population density of less than 100 people per square mile;

(B) independent hospitals as defined in Subsection (1)(e); and

(C) federally qualified health centers as defined in Subsection (1)(d).

(d) (i) A health maintenance organization shall:

(A) use the information developed by the commissioner under Subsection [~~(7)~~] (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are located in the health maintenance organization's service area; and

(B) include the providers identified under Subsection [~~(7)~~] (8)(d)(i)(A) in the notice required in Subsection [~~(7)~~] (8)(d)(ii).

(ii) The health maintenance organization shall provide the following notice, in bold type, to enrollees as specified under Subsection [~~(7)~~] (8)(b)(i), and shall keep the notice current:

"You may be entitled to coverage for health care services from the following non-HMO contracted providers if you live or reside within 30 paved road miles of the listed providers, or if you live or reside in closer proximity to the listed providers than to your HMO contracted providers:

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider on this list you may contact your health maintenance organization at _____. If the HMO does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

(e) A person whose interests are affected by an alleged violation of this section may contact the Office of Consumer Health Assistance and request assistance, or file a complaint as provided in Section 31A-2-216.

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

31A-22-613.5. Price and value comparisons of health insurance -- Basic Health Care Plan.

(1) (a) Except as provided in Subsection (1)(b), this section applies to all health insurance policies and health maintenance organization contracts.

(b) Subsection [~~(3)~~] (2) applies to:

(i) all health insurance policies and health maintenance organization contracts; and

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

[~~(2) The commissioner shall adopt a Basic Health Care Plan consistent with this section to be offered under the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act.~~]

[~~(3)~~] (2) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer issuing health insurance policies or health maintenance organization contracts to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, written disclosure of:

(i) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution;

(ii) coverage limits under the plan; and

(iii) any limitation or exclusion of coverage including:

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

(B) beginning July 1, 2009, easily understood examples of a limitation or exclusion of coverage for a secondary medical condition.

(b) In addition to the requirements of Subsections [~~(3)~~] (2)(a), (d), and (e) an insurer described in Subsection [~~(3)~~] (2)(a) shall file the written disclosure required by this Subsection [~~(3)~~] (2) to the commissioner:

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

(ii) anytime the insurer amends any of the following described in Subsection [~~(3)(a)~~] (2):

(A) treatment policies;

(B) practice standards;

(C) restrictions;

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

(E) limitations or exclusions of coverage including a limitation or exclusion for a

secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection [~~(3)~~] (2), taking into account:

(i) business confidentiality of the insurer;

(ii) definitions of terms;

(iii) the method of disclosure to enrollees; and

(iv) limitations and exclusions.

(d) If under Subsection [~~(3)~~] (2)(a)(i) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

[~~(e) Before December 1, 2008, insurers subject to this Subsection (3) shall report to the Legislature's Health and Human Services Interim Committee and Business and Labor Interim Committee, either collectively or independently regarding insurer efforts to inform enrollees of any limitation of coverage or exclusion for a secondary medical condition when an enrollee, or someone on the enrollee's behalf, contacts the insurer for pre-authorization of a procedure or use of a drug that is excluded or limited from coverage.~~]

[~~(f)~~] (e) (i) The department shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection [~~(3)~~] (2)(a)(iii).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection [~~(3)~~] (2)(a)(iii) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(3) An insurer who offers a health care plan under Chapter 30, Individual, Small Employer, and Group Health Insurance Act, shall:

(a) until January 1, 2010, offer the basic health care plan described in Subsection (4) subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and

Group Health Insurance Act; and

(b) beginning January 1, 2010, offer a basic health care plan subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:

(i) is a federally qualified high deductible health plan;

(ii) has the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and

(iii) does not exceed an annual out of pocket maximum equal to three times the amount of the annual deductible.

(4) [~~The~~] Until January 1, 2010 the Basic Health Care Plan [~~adopted by the commissioner~~] under this section shall provide for:

(a) a lifetime maximum benefit per person not [~~to exceed~~] less than $1,000,000;

(b) an annual maximum benefit per person not less than $250,000;

(c) an out-of-pocket maximum of cost-sharing features:

(i) including:

(A) a deductible;

(B) a copayment; and

(C) coinsurance;

(ii) not to exceed $5,000 per person; and

(iii) for family coverage, not to exceed three times the per person out-of-pocket maximum provided in Subsection (4)(c)(ii);

(d) in relation to its cost-sharing features:

(i) a deductible of:

(A) not less than [~~$1,500~~] $1,000 per person for major medical expenses; and

(B) for family coverage, not to exceed three times the per person deductible for major medical expenses under Subsection (4)(d)(i)(A); and

(ii) (A) a copayment of not less than:

(I) $25 per visit for office services; and

(II) $150 per visit to an emergency room; or

(B) coinsurance of not less than:

(I) 20% per visit for office services; and

(II) 20% per visit for an emergency room; and

(e) in relation to cost-sharing features for prescription drugs:

(i) (A) a deductible not to exceed $1,000 per person; and

(B) for family coverage, not to exceed three times the per person deductible provided in Subsection (4)(e)(i)(A); and

(ii) (A) a copayment of not less than:

(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or $25 for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or $35 for the highest level of cost for prescription drugs; or

(B) coinsurance of not less than:

(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.

(5) The department shall include in its yearly insurance market report information about:

(a) the types of health benefit plans sold on the Internet portal created in Section 63M-1-2504;

(b) the number of insurers participating in the defined contribution market on the Internet portal;

(c) the number of employers and covered lives in the defined contribution market; and

(d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).

(6) The commissioner may request information from an insurer to verify the information submitted by the insurer to the Internet portal under Subsection 63M-1-2506(4).

Section 3. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) (i) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care provider contracts shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions.

(b) [~~When~~] (i) Until July 1, 2012, when the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.

(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3).

(iii) The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.

(c) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(e) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(f) For purposes of this section, unfair discrimination between classes of health care providers shall include:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly utilized by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the adverse benefit determination procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are

privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Section 4. Section **31A-22-618.5** is enacted to read:

31A-22-618.5. Health plan offerings.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance

Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(D) coverage mandates enacted after January 1, 2009 that are not required by federal law **Ŝ→ , provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009 ←Ŝ** ; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from non-affiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:

(i) tier one contracted providers;

(ii) tier two contracted providers who the insurer must reimburse at least 75% of tier one providers; and

(iii) one or more tiers of non-contracted providers; and

(b) may offer a health benefit plan that is not subject to Subsection 31A-22-617(9) and

Section 31A-22-618;

(c) beginning July 1, 2012 may offer products under Subsection (3)(a) that **Ŝ→ :**

(i) **←Ŝ** are not

subject to Subsection 31A-22-617(2); and

Ŝ→ (ii) are subject to the reimbursement requirements in Section 31A-8-501; ←Ŝ

(d) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 by providing coverage at a reimbursement level of at least 75% of tier one providers **Ŝ→ ; and**

(e) are not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009 **←Ŝ** .

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsections (3)(a) and (b) shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 5. Section **31A-22-722** is amended to read:

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

(1) An insured has the right to extend the employee's coverage under the current employer's group policy for a period of [~~six~~] 12 months, except as provided in Subsection (2). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) any disability;

(i) leave of absence; or

(j) reduction of hours.

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

(i) failed to pay any required individual contribution;

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

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

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

(v) was terminated for gross misconduct;

(vi) has not been continuously covered under the current employer's group policy for a period of [~~six~~] three months immediately prior to the termination of the policy due to the events set forth in Subsection (1); [~~or~~]

(vii) is eligible for any extension of coverage required by federal law[~~.~~]; or

(viii) elected alternative coverage under Section 31A-22-724.

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

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

(i) the terminated insured;

(ii) the ex-spouse; or

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

(A) to a surviving spouse; and

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

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

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

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

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

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

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in [~~this~~] Subsection [~~(3)~~] (5) if:

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

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

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

(6) Except as provided in this Subsection (6), the coverage extends without interruption for [~~six~~] 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

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

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

(7) The insured's coverage may be terminated prior to [~~six~~] 12 months if the terminated insured:

(a) establishes residence outside of this state;

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

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

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

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

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

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

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

(a) for the balance of the period the terminated insured would have extended coverage

under the replaced group policy; and

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

(9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of the insured, the surviving spouse, or guardian of any dependents, written notification of the right to an individual conversion policy under Section 31A-22-723.

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

(i) shall be sent first class mail to:

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

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

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

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

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

Section 6. Section **31A-22-723** is amended to read:

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

(1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection (3), all policies of accident and health insurance offered on a group basis under this title, or Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that a person whose insurance under the group policy has been terminated is entitled to choose a converted individual policy [~~of similar accident and health insurance~~] in accordance with this section and Section 31A-22-724.

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

(a) has been continuously covered for a period of [~~six~~] three months by the group policy or the group's preceding policies immediately prior to termination;

(b) has exhausted either:

(i) Utah mini-COBRA coverage as required in Section 31A-22-722 [~~or~~];

(ii) federal COBRA coverage; or

(iii) alternative coverage under Section 31A-22-724;

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

(d) resides in the insurer's service area.

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

(a) is a stand alone policy that only provides one of the following:

(i) catastrophic benefits;

(ii) aggregate stop loss benefits;

(iii) specific stop loss benefits;

(iv) benefits for specific diseases;

(v) accidental injuries only;

(vi) dental; or

(vii) vision;

(b) is an income replacement policy;

(c) was terminated because the insured:

(i) failed to pay any required individual contribution;

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

(iii) made intentional misrepresentation of material fact under the terms of coverage; or

(d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or 31A-30-107(2)(a).

(4) (a) The employer shall provide written notification of the right to an individual conversion policy within 30 days of the insured's termination of coverage to:

(i) the terminated insured;

(ii) the ex-spouse; or

(iii) in the case of the death of the insured:

(A) the surviving spouse; and

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

(b) The notification required by Subsection (4)(a) shall:

(i) be sent by first class mail;

(ii) contain the name, address, and telephone number of the insurer that will provide the conversion coverage; and

(iii) be sent to the insured's last-known address as shown on the records of the employer of:

(A) the insured;

(B) the ex-spouse; and

(C) if the policy terminates by reason of the death of the insured to:

(I) the surviving spouse; and

(II) the guardian of any dependents, if different from a surviving spouse.

(5) (a) An insurer is not required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(b) Except as provided in Subsection (5)(c), if the conversion is made from a health benefit plan, the employee or member [~~must~~] shall be offered:

(i) at least the basic benefit plan as provided in Section 31A-22-613.5 through December 31, 2009; and

(ii) beginning January 1, 2010, only the alternative coverage as provided in Section 31A-22-724(1)(a).

(c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy.

(6) Written application for the converted policy shall be made and the first premium paid to the insurer no later than 60 days after termination of the group accident and health insurance.

(7) The converted policy shall be issued without evidence of insurability.

(8) (a) The initial premium for the converted policy for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to age, class of risk of the person, and the type and amount of insurance provided.

(b) The initial premium for the first 12 months may not be raised based on pregnancy of a covered insured.

(c) The premium for converted policies shall be payable monthly or quarterly as required by the insurer for the policy form and plan selected, unless another mode or premium

payment is mutually agreed upon.

(9) The converted policy becomes effective at the time the insurance under the group policy terminates.

(10) (a) A newly issued converted policy covers the employee or the member and must also cover all dependents covered by the group policy at the date of termination of the group coverage.

(b) The only dependents that may be added after the policy has been issued are children and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

(c) At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(11) (a) To the extent the group policy provided maternity benefits, the conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group policy or the conversion policy until termination of a pregnancy that exists on the date of conversion if one of the following is pregnant on the date of the conversion:

(i) the insured;

(ii) a spouse of the insured; or

(iii) a dependent of the insured.

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

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

(a) a dependent is no longer eligible under the policy;

(b) for a network plan, if the individual no longer lives, resides, or works in:

(i) the insured's service area; or

(ii) the area for which the covered carrier is authorized to do business;

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

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

(e) the individual makes an intentional misrepresentation of material fact under the

terms of the coverage; or

(f) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

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

Section 7. Section **31A-22-724** is enacted to read:

31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.

(1) For purposes of this section, "alternative coverage" means:

(a) the high deductible or low deductible Utah NetCare Plan described in Subsection (2) for conversion policies offered under Section 31A-22-723; and

(b) the high deductible and low deductible Utah NetCare Plans described in Subsection (2) as an alternative to COBRA and mini-COBRA policies offered under Section 31A-22-722.

(2) The Utah NetCare Plans shall include:

(a) healthy lifestyle and wellness incentives;

(b) the benefits described in this Subsection (2) or at least the actuarial equivalent of the benefits described in this Subsection (2);

(c) a lifetime maximum benefit per person of not less than $1 million;

(d) an annual maximum benefit per person of not less than $250,000;

(e) the following deductibles:

(i) for the low deductible plans:

(A) $2,000 for an individual plan;

(B) $4,000 for a two party plan; and

(C) $6,000 for a family plan;

(ii) for the high deductible plans:

(A) $4,000 for an individual plan;

(B) $8,000 for a two party plan; and

(C) $12,000 for a family plan;

(f) the following out-of-pocket maximum costs, including deductibles, copayments, and coinsurance:

(i) for the low deductible plans:

(A) $5,000 for an individual plan;

(B) $10,000 for a two party plan; and

(C) $15,000 for a family plan; and

(ii) for the high deductible plan:

(A) $10,000 for an individual plan;

(B) $20,000 for a two party plan; and

(C) $30,000 for a family plan;

(g) the following benefits before applying any deductible requirements and in accordance with IRC Section 223:

(i) all well child exams and immunizations up to age five, with no annual maximum;

(ii) preventive care up to a $500 annual maximum;

(iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i) or (ii) up to a $300 annual maximum; and

(iv) supplemental accident coverage up to a $500 annual maximum;

(h) the following copayments for each exam:

(i) $15 for preventive care and well child exams;

(ii) $25 for primary care; and

(iii) $50 for urgent care and specialist care;

(i) a $200 copayment for emergency room visits after applying the deductible;

(j) no more than a 30% coinsurance after deductible for covered plan benefits for hospital services, maternity, laboratory work, x-rays, radiology, outpatient surgery services, injectable medications not otherwise covered under a pharmacy benefit, durable medical equipment, ambulance services, in-patient mental health services, and out-patient mental health services; and

(k) the following cost-sharing features for prescription drugs:

(i) up to a $15 copayment for generic drugs;

(ii) up to a 50% coinsurance for name brand drugs; and

(iii) may include formularies and preferred drug lists.

(3) The Utah NetCare Plans may exclude:

(a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and

(b) unless required by federal law, mandated coverage required by the following sections and related administrative rules:

(i) Section 31A-22-610.1, Adoption indemnity benefits;

(ii) Section 31A-22-623, Inborn metabolic errors;

(iii) Section 31A-22-624, Primary care physicians;

(iv) Section 31A-22-626, Coverage of diabetes;

(v) Section 31A-22-628, Standing referral to a specialist; and

(vi) coverage mandates enacted after January 1, 2009 that are not required by federal law.

(4) (a) Beginning January 1, 2010, and except as provided in Subsection (5), a person may elect alternative coverage under this section if the person:

(i) is eligible for continuation of employer group coverage under federal COBRA laws;

(ii) is eligible for continuation of employer group coverage under state mini-COBRA under Section 31A-22-722; or

(iii) is eligible for a conversion to an individual plan after the exhaustion of benefits under:

(A) alternative coverage elected in place of federal COBRA; or

(B) state mini-COBRA under Section 31A-22-722.

(b) The right to extend coverage under Subsection (4)(a) applies to any spouse or dependent coverages, including a surviving spouse or dependent whose coverage under the policy terminates by reason of the death of the employee or member.

(5) If a person elects federal COBRA coverage, or state mini-COBRA coverage under Section 31A-22-722, the person is not eligible to elect alternative coverage under this section until the person is eligible to convert coverage to an individual policy under the provisions of Section 31A-22-723 and Subsection (1)(a).

(6) (a) If the alternative coverage is selected as an alternative to COBRA or mini-COBRA under Section 31A-22-722, the provisions of Section 31A-22-722 apply to the alternative coverage.

(b) If the alternative coverage is selected as a conversion policy under Section 31A-22-723, the provisions of Section 31A-22-723 apply.

(7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to September 1, 2009, file an alternative coverage policy with the department in accordance with Sections 31A-21-201 and 31A-21-201.1.

(b) The department shall, by November 1, 2009, adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to develop a model letter for employers to use to notify an employee of the employee's options for alternative coverage.

Section 8. Section **31A-23a-401** is amended to read:

31A-23a-401. Disclosure of conflicting interests.

(1) (a) Except as provided under Subsection (1)(b):

(i) a licensee under this chapter may not act in the same or any directly related transaction as:

(A) a producer for the insured or consultant; and

(B) producer for the insurer; and

(ii) a producer for the insured or consultant may not recommend or encourage the purchase of insurance from or through an insurer or other producer:

(A) of which the producer for the insured or consultant or producer for the insured's or consultant's spouse is an owner, executive, or employee; or

(B) to which the producer for the insured or consultant has the type of relation that a material benefit would accrue to the producer for the insured or consultant or spouse as a result of the purchase.

(b) Subsection (1)(a) does not apply if the following three conditions are met:

(i) Prior to performing the consulting services, the producer for the insured or consultant shall disclose to the client, prominently, in writing:

(A) the producer for the insured's or consultant's interest as a producer for the insurer, or the relationship to an insurer or other producer; and

(B) that as a result of those interests, the producer for the insured's or the consultant's recommendations should be given appropriate scrutiny.

(ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing, after the disclosure required under Subsection (1)(b)(i), but before performing the requested services.

(iii) Any report resulting from requested services shall contain a copy of the disclosure made under Subsection (1)(b)(i).

(2) A licensee under this chapter may not act as to the same client as both a producer

for the insurer and a producer for the insured without the client's prior written consent based on full disclosure.

(3) Whenever a person applies for insurance coverage through a producer for the insured, the producer for the insured shall disclose to the applicant, in writing, that the producer for the insured is not the producer for the insurer or the potential insurer. This disclosure shall also inform the applicant that the applicant likely does not have the benefit of an insurer being financially responsible for the conduct of the producer for the insured.

(4) If a licensee is subject to both this section and Subsection 31A-23a-501(4), the licensee shall provide the disclosure required under each statute.

Section 9. Section **31A-23a-501** is amended to read:

31A-23a-501. Licensee compensation.

(1) As used in this section:

(a) "Commission compensation" includes funds paid to or credited for the benefit of a licensee from:

(i) commission amounts deducted from insurance premiums on insurance sold by or placed through the licensee; or

(ii) commission amounts received from an insurer or another licensee as a result of the sale or placement of insurance.

(b) (i) "Compensation from an insurer or third party administrator" means commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration:

(A) whether or not payable pursuant to a written agreement; and

(B) received from:

(I) an insurer; or

(II) a third party to the transaction for the sale or placement of insurance.

(ii) "Compensation from an insurer or third party administrator" does not mean compensation from a customer that is:

(A) a fee or pass-through costs as provided in Subsection (1)(e); or

(B) a fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner by administrative rule.

(c) (i) "Customer" means:

(A) the person signing the application or submission for insurance; or

(B) the authorized representative of the insured actually negotiating the placement of insurance with the producer.

(ii) "Customer" does not mean a person who is a participant or beneficiary of:

(A) an employee benefit plan; or

(B) a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the producer or affiliate.

[~~(b)~~] (d) (i) "Noncommission compensation" includes all funds paid to or credited for the benefit of a licensee other than commission compensation.

(ii) "Noncommission compensation" does not include charges for pass-through costs incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

[~~(c)~~] (e) "Pass-through costs" include:

(i) costs for copying documents to be submitted to the insurer; and

(ii) bank costs for processing cash or credit card payments.

(2) A licensee may receive from an insured or from a person purchasing an insurance policy, noncommission compensation if the noncommission compensation is stated on a separate, written disclosure.

(a) The disclosure required by this Subsection (2) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(b) Noncommission compensation shall be:

(i) limited to actual or reasonable expenses incurred for services; and

(ii) uniformly applied to all insureds or prospective insureds in a class or classes of business or for a specific service or services.

(c) A copy of the signed disclosure required by this Subsection (2) must be maintained by any licensee who collects or receives the noncommission compensation or any portion [~~thereof~~] of the noncommission compensation.

(d) All accounting records relating to noncommission compensation shall be

maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

(3) (a) A licensee may receive noncommission compensation when acting as a producer for the insured in connection with the actual sale or placement of insurance if:

(i) the producer and the insured have agreed on the producer's noncommission compensation; and

(ii) the producer has disclosed to the insured the existence and source of any other compensation that accrues to the producer as a result of the transaction.

(b) The disclosure required by this Subsection (3) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation and the existence and source of any other compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(c) The following additional noncommission compensation is authorized:

(i) compensation received by a producer of a compensated corporate surety who under procedures approved by a rule or order of the commissioner is paid by surety bond principal debtors for extra services;

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

(iii) compensation received by a consultant as a consulting fee, provided the consultant complies with the requirements of Section 31A-23a-401; or

(iv) other compensation arrangements approved by the commissioner after a finding that they do not violate Section 31A-23a-401 and are not harmful to the public.

(4) (a) For purposes of this Subsection (4), "producer" includes:

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) Beginning January 1, 2010, in addition to any other disclosures required by this

section, a producer may not accept or receive any compensation from an insurer or third party administrator for the placement of §→ [~~health care insurance~~] **a health benefit plan, other than a hospital confinement indemnity policy,** ←§ unless prior to the customer's purchase §→ [~~of health care insurance~~] **the health benefit plan** ←§ the producer:

(i) except as provided in Subsection (4)(c), discloses in writing to the customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer at the time of the disclosure; and

(ii) except as provided in Subsection (4)(c):

(A) obtains the customer's signed acknowledgment that the disclosure under Subsection (4)(b)(i) was made to the customer; or

(B) certifies to the insurer that the disclosure required by Subsection (4)(b)(i) was made to the customer.

(c) If the compensation to the producer from an insurer or third party administrator is for the renewal of health care insurance, once the producer has made an initial disclosure that complies with Subsection (4)(b), the producer does not have to disclose compensation received for the subsequent yearly renewals in accordance with Subsection (4)(b) until the renewal period immediately following 36 months after the initial disclosure.

(d) (i) A copy of the signed acknowledgment required by Subsection (4)(b) must be maintained by the licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit.

(ii) The standard application developed in accordance with Section 31A-22-635 shall include a place for a producer to provide the disclosure required by Subsection (4), and if completed, shall satisfy the requirement of Subsection (4)(d)(i).

(e) Subsection (4)(b)(ii) does not apply to:

(i) a person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent; or

(ii) the placement of insurance in a secondary or residual market.

[~~(4)~~] (5) This section does not alter the right of any licensee to recover from an insured the amount of any premium due for insurance effected by or through that licensee or to charge a reasonable rate of interest upon past-due accounts.

[~~(5)~~] (6) This section does not apply to bail bond producers or bail enforcement agents

as defined in Section 31A-35-102.

Section 10. Section **31A-30-102** is amended to read:

Part 1. Individual and Small Employer Group

31A-30-102. Purpose statement.

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market; [~~and~~]

(5) provide increased access for individuals and small employers to health insurance[~~.~~]; and

(6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the Internet portal created by Section 63M-1-2504.

Section 11. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for

health benefit plans with the same or similar coverage.

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under [~~Subsection~~] Section 31A-22-613.5[~~(2)~~].

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds established under Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is not a plan document, the plan year is:

(a) the deductible or limit year used under the plan;

(b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

(c) if the plan does not impose a deductible or limit on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer's

taxable year; or

(d) in any case not described in Subsections (20)(a) through (c), the calendar year.

(21) "Preexisting condition" is as defined in Section 31A-1-301.

(22) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(23) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(24) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(25) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(26) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(27) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting

criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

(28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Section 12. Section **31A-30-104** is amended to read:

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers; or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) a large employer health benefit plan, except as specifically provided in Part 2, Defined Contribution Arrangements;

(b) short-term limited duration health insurance; or

(c) federally funded or partially funded programs.

(4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if the ceding arrangements would result in less than 50% of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

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

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

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

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

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

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

(6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and

31A-30-111 apply to:

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

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

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

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer; and

(d) an insurance consultant.

Section 13. Section **31A-30-107** is amended to read:

31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a small employer health benefit plan is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's minimum participation requirements.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 14. Section **31A-30-109** is amended to read:

31A-30-109. Health benefit plan choices.

(1) An individual carrier who offers individual coverage pursuant to Section 31A-30-108:

(a) shall offer in the individual market under this chapter:

(i) a choice of coverage that is at least equal to or greater than basic coverage[.]; and

(ii) beginning January 1, 2010, the Utah NetCare Plan described in Subsection 31A-22-724(2); and

(b) may offer a choice of coverage that:

(i) costs less than or equal to the plan described in Subsection (1)(a)(ii); and

(ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

(2) Beginning January 1, 2010, a small employer group carrier who offers small

employer group coverage pursuant to Section 31A-30-108:

(a) shall offer in the small employer group market under this part:

(i) a choice of coverage that is at least equal to or greater than basic coverage; and

(ii) coverage under the Utah NetCare Plan described in Section 31A-22-724; and

(b) may offer in the small employer group market under this part, a choice of coverage that:

(i) costs less than or equal to the coverage in Subsection (2)(a); and

(ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

(3) Nothing in this section limits the number of health benefit plans an insurer may offer.

Section 15. Section **31A-30-112** is amended to read:

31A-30-112. Employee participation levels.

(1) (a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including a requirement for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require that a small employer have a minimum of two eligible employees to meet participation requirements.

(2) A covered carrier may not increase a requirement for minimum employee participation or a requirement for minimum employer contribution applicable to a small employer at any time after the small employer is accepted for coverage.

Section 16. Section **31A-30-201** is enacted to read:

Part 2. Defined Contribution Arrangements

31A-30-201. Title.

This part is known as "Defined Contribution Arrangements."

Section 17. Section **31A-30-202** is enacted to read:

31A-30-202. Definitions.

For purposes of this part:

(1) "Defined contribution arrangement" means a defined contribution arrangement employer group health benefit plan that:

(a) complies with this part; and

(b) is sold through the Internet portal in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) "Health reimbursement arrangement" means an employer provided health reimbursement arrangement in which reimbursements for medical care expenses are excluded from an employee's gross income under the Internal Revenue Code.

(3) "Producer" is as defined in Subsection 31A-23a-501(4)(a).

(4) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies under Section 125, Internal Revenue Code which permits an employee to contribute pre-tax dollars to a health benefit plan.

(5) "Small employer" is defined in Section 31A-1-301.

Section 18. Section **31A-30-203** is enacted to read:

31A-30-203. Eligibility for defined contribution arrangement market -- Enrollment.

(1) (a) Beginning January 1, 2010, and during the open enrollment period described in Section 31A-30-208, an eligible small employer may choose to participate in a defined contribution arrangement.

(b) Beginning January 1, 2012, and during the open enrollment period described in Section 31A-30-208, an eligible large employer may choose to participate in a defined contribution arrangement.

(c) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer.

(2) (a) Participating insurers:

(i) shall offer to accept all eligible employees of an employer described in Subsection (1), and their dependents at the same level of benefits as anyone else who has the same health benefit plan in the defined contribution arrangement market; and

(ii) may not impose a premium surcharge under Section 31A-30-106.7 in the defined contribution market.

(b) A participating insurer may:

(i) request an employer to submit a copy of the employer's quarterly wage list to determine whether the employees for whom coverage is provided or requested are bona fide employees of the employer; and

(ii) deny or terminate coverage if the employer refuses to provide documentation requested under Subsection (2)(b)(i).

Section 19. Section **31A-30-204** is enacted to read:

31A-30-204. Employer responsibilities -- Defined contribution arrangements.

(1) (a) (i) An employer described in Subsection 31A-30-203(1) that chooses to participate in a defined contribution arrangement may not offer a major medical health benefit plan that is not a part of the defined contribution arrangement to an employee.

(ii) Subsection (1)(a)(i) does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts for health care expenses.

(b) (i) To the extent permitted by the risk adjustment plan adopted under Section 31A-42-202, the employer reserves the right to determine:

(A) the criteria for employee eligibility, enrollment, and participation in the employer's health benefit plan; and

(B) the amount of the employer's contribution to that plan.

(ii) The determinations made under Subsection (1)(b) may only be changed during periods of open enrollment.

(2) An employer that chooses to establish a defined contribution arrangement to provide a health benefit plan for its employees shall:

(a) establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the Internet portal created in Section 63M-1-2504, which may include:

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

(iii) another plan or arrangement similar to Subsection (2)(a)(i) or (ii) which is excluded or deducted from gross income under the Internal Revenue Code;

(b) by November 10 of the open enrollment period:

(i) inform each employee of the health benefit plan the employer has selected as the

default health benefit plan for the employer group;

(ii) offer each employee a choice of any of the health benefit plans available through the defined contribution arrangement market on the Internet portal; and

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, prior to November 25 of the open enrollment period:

(A) notifies the employer that the employee has selected a different health benefit plan available through the defined contribution arrangement in the Internet portal;

(B) provides proof of coverage from another health benefit plan; or

(C) specifically declines coverage in a health benefit plan.

(3) An employer shall enroll an employee in the default health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection (2)(b)(ii) prior to November 25 of the open enrollment period.

(4) The employer's notice to the employee under Subsection (2)(b)(iii) shall inform the employee that the failure to act under Subsections (2)(b)(iii)(A) through (C) is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

Section 20. Section **31A-30-205** is enacted to read:

31A-30-205. Health benefit plans offered in the defined contribution market.

(1) An insurer who chooses to offer a health benefit plan in the defined contribution market must offer the following:

(a) one health benefit plan that:

(i) is a federally qualified high deductible health plan;

(ii) has the lowest deductible permitted for a federally qualified high deductible health plan as adjusted by federal law; and

(iii) does not exceed annual out-of-pocket maximum equal to three times the amount of the annual deductible; and

(b) one health benefit plan with benefits that have an actuarial value at least 15% greater that the plan described in Subsection (1)(a).

(2) The provisions of Subsection (1) do not limit the number of health benefit plans an insurer may offer in the defined contribution market. An insurer who offers the health benefit

plans required by Subsection (1) may also offer any other health benefit plan in the defined contribution market if the health benefit plan provides benefits that are actuarially richer than the benefits required in Subsection (1)(a).

Section 21. Section **31A-30-206** is enacted to read:

31A-30-206. Minimum participation and contribution levels -- Premium payments.

An insurer who offers a health benefit plan for which an employer has established a defined contribution arrangement under the provisions of this part:

(1) shall not:

(a) establish an employer minimum contribution level for the health benefit plan premium under Section 31A-30-112, or any other law; or

(b) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to maintain a minimum employer contribution level;

(2) shall accept premium payments for an enrollee from multiple sources through the Internet portal, including:

(a) government assistance programs;

(b) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by any employer of the enrollee;

(c) contributions from a Section 125 Cafeteria plan, a health reimbursement arrangement, or other qualified mechanism for pre-tax payments established by an employer of a spouse or dependent of the enrollee; and

(d) contributions from private sources of premium assistance; and

(3) may require, as a condition of coverage, a minimum participation level for eligible employees of an employer, which for purposes of the defined contribution arrangement market may not exceed 75% participation.

Section 22. Section **31A-30-207** is enacted to read:

31A-30-207. Rating and underwriting restrictions for defined contribution market.

(1) The rating and underwriting restrictions for the defined contribution market shall be established in accordance with the plan adopted under Chapter 42, Defined Contribution Risk

Adjuster Act, and shall apply to employers who participate in the defined contribution arrangement market.

(2) All insurers who participate in the defined contribution market must participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act.

Section 23. Section **31A-30-208** is enacted to read:

31A-30-208. Enrollment Periods for the Defined Contribution Market.

(1) From November 1 to November 30 of each year an insurer offering a product in the defined contribution market shall administer an open enrollment period for plans effective January 1 following the November open enrollment period, during which an eligible employee may enroll in a health benefit plan offered through the defined contribution market and may not be declined coverage.

(2) (a) Except as provided in Subsection (4), the period of open enrollment is the time in which an insurer may:

(i) enter or exit the defined contribution market;

(ii) offer new or modify existing products in the defined contribution market; or

(iii) withdraw products from the defined contribution market.

(b) Ninety days prior to an open enrollment period under Subsection (1), an insurer shall notify the Internet portal and the risk adjuster board created in Chapter 42, Defined Contribution Risk Adjuster Act, regarding any of the events described in Subsection (2)(a).

(3) An eligible employee may enroll in a health benefit plan offered in the defined contribution market and may not be declined coverage, at a time other than the annual open enrollment period for any of the circumstances recognized as permissible under federal tax law, provided the individual does so within 63 days of the permissible circumstance.

(4) When an insurer elects to participate in the defined contribution market, the insurer shall participate in the defined contribution market for no less than two years.

Section 24. Section **31A-42-101** is enacted to read:

CHAPTER 42. DEFINED CONTRIBUTION RISK ADJUSTER ACT

Part 1. General Provisions

31A-42-101. Title.

This chapter is known as the "Defined Contribution Risk Adjuster Act."

Section 25. Section **31A-42-102** is enacted to read:

31A-42-102. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the Utah Defined Contribution Risk Adjuster created in Section 31A-42-201.

(2) "Risk adjuster" means the defined contribution risk adjustment mechanism created in Section 31A-42-201.

Section 26. Section **31A-42-103** is enacted to read:

31A-42-103. Applicability and scope.

This chapter applies to a carrier as defined in Section 31A-30-103 who offers a health benefit plan in a defined contribution arrangement under Chapter 30, Part 2, Defined Contribution Arrangements.

Section 27. Section **31A-42-201** is enacted to read:

Part 2. Creation of Risk Adjuster Mechanism

31A-42-201. Creation of defined contribution market risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity within the Insurance Department.

(2) (a) The risk adjuster shall be under the direction of a board of directors composed of up to nine members described in Subsection (2)(b).

(b) The following directors shall be appointed by the governor with the consent of the Senate:

(i) at least three, but up to five directors with actuarial experience who represent insurance carriers:

(A) that are participating or have committed to participate in the defined contribution arrangement market in the state; and

(B) including at least one and up to two directors who represent a carrier that has a small percentage of lives in the defined contribution market;

(ii) one director who represents either an individual employee or employer participant in the defined contribution market;

(iii) one director appointed by the governor to represent the Office of Consumer Health

Services within the Governor's Office of Economic Development;

(iv) one director representing the Public Employee's Health Benefit Program with actuarial experience, chosen by the director of the Public Employee's Health Benefit Program who shall serve as an ex officio member; and

(v) the commissioner or a representative from the department with actuarial experience appointed by the commissioner, who will only have voting privileges in the event of a tie vote.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members appointed by the governor expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) (a) Members who are not government employees shall receive no compensation or benefits for the members' services.

(b) A state government member who is a member because of the member's state government position may not receive per diem or expenses for the member's service.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) Six board members are a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

Section 28. Section **31A-42-202** is enacted to read:

31A-42-202. Contents of plan.

(1) The board shall submit a plan of operation for the risk adjuster to the commissioner. The plan shall:

(a) establish the methodology for implementing Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements;

(b) establish regular times and places for meetings of the board;

(c) establish procedures for keeping records of all financial transactions and for

sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and

(ii) underwriting mechanisms and employer eligibility guidelines:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.

(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual are determined, including:

(i) the identification of an initial rate for a qualified individual based on:

(A) standardized age bands submitted by participating insurers; and

(B) wellness incentives for the individual as permitted by federal law; and

(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.

(c) The plan adopted under Subsection (2)(a) shall outline how:

(i) premium contributions for qualified individuals shall be submitted to the Internet portal in the amount determined under Subsection (2)(b); and

(ii) the Internet portal shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's health risk factor determined in accordance with the plan.

(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between insurers that:

(i) identifies health care conditions subject to risk adjustment;

(ii) establishes an adjustment amount for each identified health care condition;

(iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and

(iv) computes all risk adjustments.

(e) The board may amend the plan if necessary to:

(i) maintain the solvency of the defined contribution market;

(ii) mitigate significant issues of risk selection; or

(iii) improve the administration of the risk adjuster mechanism.

Section 29. Section **31A-42-203** is enacted to read:

31A-42-203. Powers and duties of board.

(1) The board shall have the power to:

(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking legal action necessary to implement and enforce the plan for risk adjustment adopted pursuant to this chapter; and

(c) establish appropriate rate adjustments, underwriting policies, and other actuarial functions appropriate to the operation of the defined contribution arrangement market in accordance with Section 31A-42-202.

(2) (a) The board shall prepare and submit an annual report to the department for inclusion in the department's annual market report, which shall include:

(i) the expenses of administration of the risk adjuster for the defined contribution arrangement market;

(ii) a description of the types of policies sold in the defined contribution arrangement market;

(iii) the number of insured lives in the defined contribution arrangement market; and

(iv) the number of insured lives in health benefit plans that do not include state mandates.

(b) The budget for operation of the risk adjuster is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter

shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

(3) The board shall report to the Health Reform Task Force and to the Legislative Management Committee prior to October 1, 2009 and again prior to October 1, 2010 regarding:

(a) the board's progress in developing the plan required by this chapter; and

(b) the board's progress in:

(i) expanding choice of plans in the defined contribution market; and

(ii) expanding access to the defined contribution market in the Internet portal for large employer groups.

Section 30. Section **31A-42-204** is enacted to read:

31A-42-204. Powers of commissioner.

(1) The commissioner shall, after notice and hearing, approve the plan of operation if the commissioner determines that the plan:

(a) is consistent with this chapter; and

(b) is a fair and reasonable administration of the risk adjuster.

(2) The plan shall be effective upon the adoption of administrative rules by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any time thereafter fails to submit proposed amendments to the plan of operation within a reasonable time after requested by the commissioner, the commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

(4) Rules promulgated by the commissioner shall continue in force until modified by the commissioner or until superseded by a subsequent plan of operation submitted by the board and approved by the commissioner.

(5) The commissioner may designate an executive secretary from the department to provide administrative assistance to the board in carrying out its responsibilities.

Section 31. Section **63M-1-2504** is amended to read:

63M-1-2504. Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under [~~Section~~] Sections 31A-22-635 and 63M-1-2506, create an Internet portal that:

(i) is capable of providing access to private and government health insurance websites and their electronic application forms and submission procedures;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Internet portal by an insurer for the:

(A) small employer group market;

(B) the individual market; and

(C) the defined contribution arrangement market; and

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others by educating employers and insurers about collection services available through private vendors, including financial institutions; [~~and~~]

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars[~~.~~];

(d) periodically convene health care providers, payers, and consumers to monitor the progress being made regarding demonstration projects for health care delivery and payment reform; and

(e) report to the Business and Labor Interim Committee and the Health Reform Task Force prior to November 1, 2009 and November 1, 2010 regarding:

(i) the operations of the Internet portal required by this chapter; and

(ii) the progress of the demonstration projects for health care payment and delivery reform.

(3) The office:

(a) may not:

[~~(a)~~] (i) regulate health insurers, health insurance plans, or health insurance producers;

[~~(b)~~] (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

[~~(c)~~] (iii) act as an appeals entity for resolving disputes between a health insurer and an insured[~~.~~]; and

(b) may establish and collect a fee in accordance with Section 63J-1-303 for the transaction cost of:

(i) processing an application for a health benefit plan from the Internet portal to an insurer; and

(ii) accepting, processing, and submitting multiple premium payment sources.

Section 32. Section **63M-1-2506** is enacted to read:

63M-1-2506. Health benefit plan information on Internet portal -- Insurer transparency.

(1) (a) The office shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that:

(i) establish uniform electronic standards for:

(A) a health insurer to use when:

(I) transmitting information to the Internet portal; or

(II) receiving information from the Internet portal; and

(B) facilitating the transmission and receipt of premium payments from multiple sources in the defined contribution arrangement market;

(ii) designate the level of detail that would be helpful for a concise consumer comparison of the items described in Subsections (4)(a) through (d) on the Internet portal; and

(iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on the Internet portal with the determination of when an employer is eligible to participate in the Internet portal defined contribution market under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements.

(b) The office shall post or facilitate the posting of:

(i) the information required by this section on the Internet portal created by this part; and

(ii) links to websites that provide cost and quality information from the Department of Health Data Committee or neutral entities with a broad base of support from the provider and payer communities.

(2) A health insurer shall use the uniform electronic standards when transmitting information to the Internet portal or receiving information from the Internet portal.

(3) (a) An insurer who participates in the defined contribution arrangement market under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans offered in that market on the Internet portal and shall comply with the provisions of this section.

(b) An insurer who offers products under Title 31A, Chapter 30, Part 1, Individual and Small Employer Group:

(i) shall post the basic benefit plan required by Section 31A-22-613.5 for individual and small employer group plans on the Internet portal if the insurer's plans are offered to the general public;

(ii) may publish any other health benefit plans that it offers on the Internet portal; and

(iii) shall comply with the provisions of this section for every health benefit plan it posts on the Internet portal.

(4) A health insurer shall provide the Internet portal with the following information for each health benefit plan submitted to the Internet portal:

(a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;

(b) provider networks;

(c) wellness programs and incentives;

(d) descriptions of prescription drug benefits, exclusions, or limitations; and

(e) at the same time as information is submitted under Subsection 31A-30-208(2), the following operational measures for each health insurer that submits information to the Internet portal:

(i) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and

(ii) the number of adverse benefit determinations by the insurer which were subsequently overturned on independent review under Section 31A-22-629 as a percentage of total claims paid by the insurer for the prior year.

(5) The Insurance Department shall post on the Internet portal the Insurance Department's solvency rating for each insurer who posts a health benefit plan on the Internet

portal. The solvency rating for each carrier shall be based on methodology established by the Insurance Department by administrative rule and shall be updated each calendar year.

(6) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the Internet portal under this section.

(7) A health insurer shall accept and process an application for a health benefit plan from the Internet portal in accordance with Section 31A-22-635.

Section 33. **Health Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

(1) There is created the Health Reform Task Force consisting of the following 11 members:

(a) four members of the Senate appointed by the president of the Senate, no more than three of whom may be from the same political party; and

(b) seven members of the House of Representatives appointed by the speaker of the House of Representatives, no more than five of whom may be from the same political party.

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a co-chair of the committee.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a co-chair of the committee.

(3) In conducting its business, the committee shall comply with the rules of legislative interim committees.

(4) Salaries and expenses of the members of the committee shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override Sessions.

(5) The Office of Legislative Research and General Counsel shall provide staff support to the committee.

Section 34. **Duties -- Interim report.**

(1) The committee shall review and make recommendations on the following issues:

(a) the state's progress in implementing the strategic plan for health system reform as described in Section 63M-1-2505;

(b) the implementation of statewide demonstration projects to provide systemwide

aligned incentives for the appropriate delivery of and payment for health care;

(c) the development of the defined contribution arrangement market and the plan developed by the risk adjuster board for implementation by January 1, 2012, including:

(i) increased selection of health benefit plans in the defined contribution market;

(ii) participation by large employer groups in the defined contribution market; and

(iii) risk allocation in the defined contribution market;

(d) the operations and progress of the Internet portal;

(e) mechanisms to increase transparency in the market, including:

(i) developing measurements and methodology for insurers to provide medical loss ratios as a percentage of premiums; and

(ii) administrative overhead as a percentage of total revenue;

(f) the implementation and effectiveness of insurer wellness programs and incentives, including outcome measures for the programs; and

(g) clarification from the U.S. Department of Labor regarding whether the federal Health Insurance Portability and Accountability Act, federal ERISA laws, and the Internal Revenue Code will permit an employer to offer pre-tax income to an individual for the purchase of a health benefit policy in the defined contribution market and allow the individual to purchase a health benefit policy that:

(i) is owned by the individual, separate from the employer group plan; and

(ii) is not subject to the employment relationship with the employer and is therefore fully portable.

(h) development of strategies for promoting health and wellness and highlighting the health risks associated with such things as obesity and sedentary lifestyles;

(i) providing greater transparency for consumers by:

(A) increasing the ability of individuals to obtain pre-service estimates from health care providers;

(B) determining, with providers, payers and consumers how to make the insurance explanation of benefits more understandable;

(C) determining if the terminology used by insurers regarding copayments, deductibles and cost sharing can be standardized or made more understandable to consumers and providers; and

(D) developing with providers and insurers a more efficient process for pre-authorization from an insurer for a medical procedure;

(j) the nature and significance of cost shifting between public programs and private insurance, and exploring strategies for reducing the level of the cost shift;

(k) the role that the Public Employees Health Program and other associations that provide insurance may play in the defined contribution market portal;

(l) the development of strategies to keep community leaders, business leaders and the public involved in the process of health care reform;

(m) the development of a process to help the public understand the circumstances underlying significant cost increase within the healthcare market or regional treatment variances; and

(n) the consideration of insurance reimbursement disincentives for a healthcare provider to choose the most effective and efficient treatment method for a patient.

(2) A final report, including any proposed legislation shall be presented to the Business and Labor Interim Committee before November 30, 2009.

Section 35. **Effective date.**

If approved by two-thirds of all the members elected to each house, this bill takes effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override.

Section 36. **Repeal date.**

The Health System Reform Task Force created in Sections 33 and 34 of this bill is repealed December 30, 2009.

H.B. 188 2nd Sub. (Gray) - Health System Reform - Insurance Market

Fiscal Note

2009 General Session

State of Utah

State Impact

Enactment of this bill will require an ongoing appropriation from dedicated credits of $70,000 per year beginning in FY 2010. An additional $100,000 in one-time dedicated credits may be required in FY 2012 for actuarial services.

	2009 Approp.	2010 Approp.	2011 Approp.	2009 Revenue	2010 Revenue	2011 Revenue
Dedicated Credits	$0	$70,000	$70,000	$0	$0	$0
Total	**$0**	**$70,000**	**$70,000**	**$0**	**$0**	**$0**

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals or local governments. Certain businesses may incur costs associated with reform efforts.

3/5/2009, 9:09:21 AM, Lead Analyst: Schoenfeld, J.D.

Office of the Legislative Fiscal Analyst