

HEALTH SYSTEM REFORM - INSURANCE

MARKET

2009 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: David Clark

Senate Sponsor: _____

Cosponsors:

Brad L. Dee

David Litvack

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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, and in the conversion market;

▶ creates the Utah NetCare Plan, a low cost health benefit plan as an alternative to



29 current federal COBRA, state mini-COBRA, and conversion products;

30 ▶ requires health insurance brokers and producers to disclose their commissions and
31 compensation to their customers prior to selling a health benefit plan;

32 ▶ modifies the number and type of products an insurer must offer in the small
33 employer group market and the individual market;

34 ▶ establishes a defined contribution arrangement market available on the Internet
35 portal, which:

36 • beginning January 1, 2010 is available to small employer groups;

37 • offers a range of health benefit plan choices to an employer's eligible
38 employees;

39 • beginning January 1, 2012, is available to eligible large employer groups; and

40 • beginning January 1, 2012, will offer a wider range of choices of health benefit
41 plans to employees;

42 ▶ establishes a board within the Insurance Department that is given the responsibility
43 to develop a risk adjustment mechanism that will apportion risk among the insurers
44 participating in the Internet portal defined contribution market to protect insurers
45 from adverse risk selection;

46 ▶ requires insurers who offer health benefit plans on the Internet portal to provide
47 greater transparency and disclose information about the plan benefits, provider
48 networks, wellness programs, claim payment practices, and solvency ratings;

49 ▶ establishes a process for a consumer to compare health plan features on the Internet
50 portal and to enroll in a health benefit plan from the Internet portal;

51 ▶ requires the Office of Consumer Health Services to convene insurers and health care
52 providers to monitor and report to the Health Reform Task Force and to the
53 Business and Labor Interim Committee regarding progress towards expanding
54 access to the defined contribution market, greater choice in the market, and payment
55 reform demonstration projects;

56 ▶ establishes limited rulemaking authority for the Office of Consumer Health Services
57 to:

58 • assist employers and insurance carriers with interacting with the Internet portal;

59 and

- 60 • facilitate the receipt and payment of health plan premium payments from
- 61 multiple sources;
- 62 ▶ authorizes the Office of Consumer Health Services to establish a fee to cover the
- 63 transaction cost associated with the Internet portal functions such as sending and
- 64 processing an application or processing multiple premium payment sources; and
- 65 ▶ re-authorizes the Health Reform Task Force for one year.

66 **Monies Appropriated in this Bill:**

67 This bill appropriates:

- 68 ▶ \$32,000 from the General Fund for fiscal year 2009-10 only, to fund the Health
- 69 System Reform Task Force.

70 **Other Special Clauses:**

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

72 **Utah Code Sections Affected:**

73 AMENDS:

- 74 **31A-8-501**, as last amended by Laws of Utah 2004, Chapters 90, 229, and 367
- 75 **31A-22-613.5**, as last amended by Laws of Utah 2008, Chapters 241 and 345
- 76 **31A-22-722**, as last amended by Laws of Utah 2006, Chapter 188
- 77 **31A-22-723**, as last amended by Laws of Utah 2008, Chapters 241 and 250
- 78 **31A-23a-401**, as last amended by Laws of Utah 2007, Chapter 307
- 79 **31A-23a-501**, as renumbered and amended by Laws of Utah 2003, Chapter 298
- 80 **31A-30-102**, as last amended by Laws of Utah 2008, Chapter 345
- 81 **31A-30-103**, as last amended by Laws of Utah 2007, Chapter 307
- 82 **31A-30-104**, as last amended by Laws of Utah 2004, Chapter 108
- 83 **31A-30-107**, as last amended by Laws of Utah 2004, Chapter 329
- 84 **31A-30-109**, as last amended by Laws of Utah 1997, Chapter 265
- 85 **31A-30-112**, as last amended by Laws of Utah 2008, Chapter 345
- 86 **63M-1-2504**, as enacted by Laws of Utah 2008, Chapter 383

87 ENACTS:

- 88 **31A-22-618.5**, Utah Code Annotated 1953
- 89 **31A-22-724**, Utah Code Annotated 1953
- 90 **31A-30-201**, Utah Code Annotated 1953

- 91 **31A-30-202**, Utah Code Annotated 1953
- 92 **31A-30-203**, Utah Code Annotated 1953
- 93 **31A-30-204**, Utah Code Annotated 1953
- 94 **31A-30-205**, Utah Code Annotated 1953
- 95 **31A-30-206**, Utah Code Annotated 1953
- 96 **31A-30-207**, Utah Code Annotated 1953
- 97 **31A-30-208**, Utah Code Annotated 1953
- 98 **31A-42-101**, Utah Code Annotated 1953
- 99 **31A-42-102**, Utah Code Annotated 1953
- 100 **31A-42-103**, Utah Code Annotated 1953
- 101 **31A-42-201**, Utah Code Annotated 1953
- 102 **31A-42-202**, Utah Code Annotated 1953
- 103 **31A-42-203**, Utah Code Annotated 1953
- 104 **31A-42-204**, Utah Code Annotated 1953
- 105 **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

122 privileges at an independent hospital or federally qualified health center.

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

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

127 (i) is either:

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

130 (B) licensed as of January 1, 2004;

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

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

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

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

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

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

148 (a) the enrollee:

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

150 (ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the
151 independent hospital than a contracting hospital;

152 (b) the independent hospital is located prior to December 31, 2000 in a county with a

153 population density of less than 100 people per square mile, or the independent hospital is
154 located in a county with a population density of less than 30 people per square mile; and

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

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

159 (a) the enrollee:

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

161 or

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

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

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

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

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

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

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

182 [~~5~~] (6) A noncontracting provider may only refer an enrollee to another
183 noncontracting provider so as to obligate the enrollee's health maintenance organization to pay

184 for the resulting services if:

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

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

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

190 (ii) is within 30 paved road miles of:

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

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

194 ~~[(7)]~~ (7) Notwithstanding this section, a health maintenance organization may contract
195 directly with an independent hospital, federally qualified health center, or credentialed staff
196 member.

197 ~~[(7)]~~ (8) (a) A health maintenance organization that violates any provision of this
198 section is subject to sanctions as determined by the commissioner in accordance with Section
199 31A-2-308.

200 (b) Violations of this section include:

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

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

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

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

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

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

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

214 (ii) identify in rule:

- 215 (A) the counties with a population density of less than 100 people per square mile;
- 216 (B) independent hospitals as defined in Subsection (1)(e); and
- 217 (C) federally qualified health centers as defined in Subsection (1)(d).

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

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

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

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

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

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

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

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

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

242 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**
243 **Care Plan.**

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

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

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

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

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

252 ~~[(3)]~~ (2) (a) The commissioner shall promote informed consumer behavior and
253 responsible health insurance and health plans by requiring an insurer issuing health insurance
254 policies or health maintenance organization contracts to provide to all enrollees, prior to
255 enrollment in the health benefit plan or health insurance policy, written disclosure of:

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

258 (ii) coverage limits under the plan; and

259 (iii) any limitation or exclusion of coverage including:

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

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

264 (b) In addition to the requirements of Subsections ~~[(3)]~~ (2)(a), (d), and (e) an insurer
265 described in Subsection ~~[(3)]~~ (2)(a) shall file the written disclosure required by this Subsection
266 ~~[(3)]~~ (2) to the commissioner:

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

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

269 (2):

270 (A) treatment policies;

271 (B) practice standards;

272 (C) restrictions;

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

274 (E) limitations or exclusions of coverage including a limitation or exclusion for a
275 secondary medical condition related to a limitation or exclusion of the insurer's health
276 insurance plan.

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

- 279 (i) business confidentiality of the insurer;
- 280 (ii) definitions of terms;
- 281 (iii) the method of disclosure to enrollees; and
- 282 (iv) limitations and exclusions.

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

- 285 (i) the drugs included;
- 286 (ii) the patented drugs not included;
- 287 (iii) any conditions that exist as a precedent to coverage; and
- 288 (iv) any exclusion from coverage for secondary medical conditions that may result
289 from the use of an excluded drug.

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

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

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

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

304 (a) until January 1, 2010, offer the basic health care plan described in Subsection (4)
305 subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and
306 Group Health Insurance Act; and

307 (b) beginning January 1, 2010, offer a basic health care plan subject to the open

308 enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance
309 Act, that:

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

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

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

315 (4) ~~[The]~~ Until January 1, 2020 the Basic Health Care Plan ~~[adopted by the~~
316 ~~commissioner]~~ under this section shall provide for:

317 (a) a lifetime maximum benefit per person not to exceed \$1,000,000;

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

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

320 (i) including:

321 (A) a deductible;

322 (B) a copayment; and

323 (C) coinsurance;

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

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

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

328 (i) a deductible of:

329 (A) not less than \$1,500 per person for major medical expenses; and

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

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

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

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

335 (B) coinsurance of not less than:

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

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

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

339 (i) (A) a deductible not to exceed \$1,000 per person; and
340 (B) for family coverage, not to exceed three times the per person deductible provided
341 in Subsection (4)(e)(i)(A); and
342 (ii) (A) a copayment of not less than:
343 (I) the lesser of the cost of the prescription drug or \$15 for the lowest level of cost for
344 prescription drugs;
345 (II) the lesser of the cost of the prescription drug or \$25 for the second level of cost for
346 prescription drugs; and
347 (III) the lesser of the cost of the prescription drug or \$35 for the highest level of cost
348 for prescription drugs; or
349 (B) coinsurance of not less than:
350 (I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for
351 prescription drugs;
352 (II) the lesser of the cost of the prescription drug or 40% for the second level of cost for
353 prescription drugs; and
354 (III) the lesser of the cost of the prescription drug or 60% for the highest level of cost
355 for prescription drugs.
356 (5) The department shall include in its yearly insurance market report information
357 about:
358 (a) the types of health benefit plans sold on the Internet portal created in Section
359 63M-1-2504; and
360 (b) the number of lives covered by health benefit plans that do not include state
361 mandates as permitted by Subsection 31A-30-109(2).
362 (6) The commissioner may request information from an insurer to verify the
363 information submitted by the insurer to the Internet portal under Subsection 63M-1-2506(4).
364 Section 3. Section **31A-22-618.5** is enacted to read:
365 **31A-22-618.5. Health plan offerings.**
366 (1) The purpose of this section is to increase the range of health benefit plans available
367 in the small group, small employer group, large group, and individual insurance markets.
368 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
369 Organizations and Limited Health Plans:

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

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

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

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

376 (B) the limitation on point of service products in Subsections 31A-8-408(3) through
377 (6);

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

380 (D) coverage mandates enacted after January 1, 2009 that are not required by federal
381 law; and

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

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

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

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

393 (a) shall offer to a potential purchaser at least one health benefit plan that is subject to
394 Sections 31A-22-617 and 31A-22-618;

395 (b) may offer to potential purchasers one or more health benefit plans that:

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

397 (A) Subsection 31A-22-617(2);

398 (B) Subsection 31A-22-617(7);

399 (C) Section 31A-22-618, notwithstanding Subsection 31A-22-617(9); or

400 (D) coverage mandates enacted after January 1, 2009 that are not required by federal

401 law; and

402 (ii) (A) are subject to Section 31A-8-501; and

403 (B) when offering a health plan under this section, shall provide coverage of

404 emergency care services as required by Section 31A-22-627 by providing coverage in

405 accordance with Subsection 31A-22-617(2).

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

407 Subsection (2)(b).

408 (5) (a) Any difference in price between a health benefit plan offered under Subsections

409 (2)(a) and (b) shall be based on actuarially sound data.

410 (b) Any difference in price between a health benefit plan offered under Subsections

411 (3)(a) and (b) shall be based on actuarially sound data.

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

413 offer.

414 Section 4. Section **31A-22-722** is amended to read:

415 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

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

418 The right to extend coverage includes:

419 (a) voluntary termination;

420 (b) involuntary termination;

421 (c) retirement;

422 (d) death;

423 (e) divorce or legal separation;

424 (f) loss of dependent status;

425 (g) sabbatical;

426 (h) any disability;

427 (i) leave of absence; or

428 (j) reduction of hours.

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

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

- 432 (ii) acquires other group coverage covering all preexisting conditions including
433 maternity, if the coverage exists;
- 434 (iii) performed an act or practice that constitutes fraud in connection with the coverage;
- 435 (iv) made an intentional misrepresentation of material fact under the terms of the
436 coverage;
- 437 (v) was terminated for gross misconduct;
- 438 (vi) has not been continuously covered under the current employer's group policy for a
439 period of [~~six~~] three months immediately prior to the termination of the policy due to the events
440 set forth in Subsection (1); [~~or~~]
- 441 (vii) is eligible for any extension of coverage required by federal law[~~;~~]; or
442 (viii) elected alternative coverage under Section 31A-22-724.
- 443 (b) The right to extend coverage under Subsection (1) applies to any spouse or
444 dependent coverages, including a surviving spouse or dependents whose coverage under the
445 policy terminates by reason of the death of the employee or member.
- 446 (3) (a) The employer shall provide written notification of the right to extend group
447 coverage and the payment amounts required for extension of coverage, including the manner,
448 place, and time in which the payments shall be made to:
- 449 (i) the terminated insured;
- 450 (ii) the ex-spouse; or
- 451 (iii) if Subsection (2)(b) applies:
- 452 (A) to a surviving spouse; and
- 453 (B) the guardian of surviving dependents, if different from a surviving spouse.
- 454 (b) The notification shall be sent first class mail within 30 days after the termination
455 date of the group coverage to:
- 456 (i) the terminated insured's home address as shown on the records of the employer;
- 457 (ii) the address of the surviving spouse, if different from the insured's address and if
458 shown on the records of the employer;
- 459 (iii) the guardian of any dependents address, if different from the insured's address, and
460 if shown on the records of the employer; and
- 461 (iv) the address of the ex-spouse, if shown on the records of the employer.
- 462 (4) The insurer shall provide the employee, spouse, or any eligible dependent the

463 opportunity to extend the group coverage at the payment amount stated in [this] Subsection
464 [~~3~~] (5) if:

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

467 (b) the employee or other individual eligible for extension contacts the insurer within
468 60 days of coverage termination.

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

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

475 (a) elects to extend group coverage within 60 days of losing group coverage; and
476 (b) tenders the amount required to the employer or insurer.

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

479 (a) establishes residence outside of this state;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

510 Section 5. Section **31A-22-723** is amended to read:

511 **31A-22-723. Group and blanket conversion coverage.**

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

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

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

522 (b) has exhausted either:

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

524 (ii) federal COBRA coverage; or

- 525 (iii) alternative coverage under Section 31A-22-724;
- 526 (c) has not acquired or is not covered under any other group coverage that covers all
- 527 preexisting conditions, including maternity, if the coverage exists; and
- 528 (d) resides in the insurer's service area.
- 529 (3) This section does not apply if the person's prior group coverage:
- 530 (a) is a stand alone policy that only provides one of the following:
- 531 (i) catastrophic benefits;
- 532 (ii) aggregate stop loss benefits;
- 533 (iii) specific stop loss benefits;
- 534 (iv) benefits for specific diseases;
- 535 (v) accidental injuries only;
- 536 (vi) dental; or
- 537 (vii) vision;
- 538 (b) is an income replacement policy;
- 539 (c) was terminated because the insured:
- 540 (i) failed to pay any required individual contribution;
- 541 (ii) performed an act or practice that constitutes fraud in connection with the coverage;
- 542 or
- 543 (iii) made intentional misrepresentation of material fact under the terms of coverage; or
- 544 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or
- 545 31A-30-107(2)(a).
- 546 (4) (a) The employer shall provide written notification of the right to an individual
- 547 conversion policy within 30 days of the insured's termination of coverage to:
- 548 (i) the terminated insured;
- 549 (ii) the ex-spouse; or
- 550 (iii) in the case of the death of the insured:
- 551 (A) the surviving spouse; and
- 552 (B) the guardian of any dependents, if different from a surviving spouse.
- 553 (b) The notification required by Subsection (4)(a) shall:
- 554 (i) be sent by first class mail;
- 555 (ii) contain the name, address, and telephone number of the insurer that will provide

556 the conversion coverage; and

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

559 (A) the insured;

560 (B) the ex-spouse; and

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

562 (I) the surviving spouse; and

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

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

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

568 (i) at least the basic benefit plan as provided in Section 31A-22-613.5 through
569 December 30, 2009; and

570 (ii) beginning January 1, 2010, only the alternative coverage as provided in Section
571 31A-22-724.

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

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

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

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

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

584 (c) The premium for converted policies shall be payable monthly or quarterly as
585 required by the insurer for the policy form and plan selected, unless another mode or premium
586 payment is mutually agreed upon.

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

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

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

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

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

- 600 (i) the insured;
- 601 (ii) a spouse of the insured; or
- 602 (iii) a dependent of the insured.

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

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

- 608 (a) a dependent is no longer eligible under the policy;
- 609 (b) for a network plan, if the individual no longer lives, resides, or works in:
 - 610 (i) the insured's service area; or
 - 611 (ii) the area for which the covered carrier is authorized to do business;
- 612 (c) the individual fails to pay premiums or contributions in accordance with the terms
613 of the converted policy, including any timeliness requirements;
- 614 (d) the individual performs an act or practice that constitutes fraud in connection with
615 the coverage;
- 616 (e) the individual makes an intentional misrepresentation of material fact under the
617 terms of the coverage; or

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

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

622 Section 6. Section **31A-22-724** is enacted to read:

623 **31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**

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

625 (a) the high deductible or low deductible Utah NetCare Plan described in Subsection

626 (2) for conversion policies; and

627 (b) the high deductible and low deductible Utah NetCare Plans described in Subsection

628 (2) for COBRA and mini-COBRA policies.

629 (2) The Utah NetCare Plans shall include:

630 (a) healthy lifestyle and wellness incentives;

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

632 the benefits described in this Subsection (2);

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

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

635 (e) the following deductibles:

636 (i) for the low deductible plans:

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

638 (B) \$6,000 for a family plan;

639 (ii) for the high deductible plans:

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

641 (B) \$12,000 for a family plan;

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

644 (i) for the low deductible plans:

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

646 (B) \$15,000 for a family plan; and

647 (ii) for the high deductible plan:

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

- 649 (B) \$30,000 for a family plan;
650 (g) the following benefits before applying any deductible requirements and in
651 accordance with IRC Section 223:
652 (i) all well child exams and immunizations up to age five, with no annual maximum;
653 (ii) preventive care up to a \$500 annual maximum;
654 (iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i)
655 or (ii) up to a \$300 annual maximum; and
656 (iv) supplemental accident coverage up to a \$500 annual maximum;
657 (h) the following copayments for each exam:
658 (i) \$15 for preventive care and well child exams;
659 (ii) \$25 for primary care; and
660 (iii) \$50 for urgent care and specialist care;
661 (i) a \$200 copayment for emergency room visits after applying the deductible;
662 (j) no more than a 30% coinsurance after deductible for covered plan benefits for
663 hospital services, maternity, laboratory work, x-rays, radiology, outpatient surgery services,
664 injectable medications not otherwise covered under a pharmacy benefit, durable medical
665 equipment, ambulance services, in-patient mental health services, and out-patient mental health
666 services; and
667 (k) the following cost-sharing features for prescription drugs:
668 (i) up to a \$15 copayment for generic drugs;
669 (ii) up to a 50% coinsurance for name brand drugs; and
670 (iii) may include formularies and preferred drug lists.
671 (3) The Utah NetCare Plans may exclude:
672 (a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and
673 (b) unless required by federal law, mandated coverage required by the following
674 sections and related administrative rules:
675 (i) Section 31A-22-610.1, Adoption indemnity benefits;
676 (ii) Section 31A-22-623, Inborn metabolic errors;
677 (iii) Section 31A-22-624, Primary care physicians;
678 (iv) Section 31A-22-626, Coverage of diabetes;
679 (v) Section 31A-22-628, Standing referral to a specialist; or

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

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

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

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

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

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

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

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

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

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

700 (b) If the alternative coverage is selected as a conversion policy under Section
701 31A-22-723, the provisions of Section 31A-22-723 apply.

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

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

709 Section 7. Section **31A-23a-401** is amended to read:

710 **31A-23a-401. Disclosure of conflicting interests.**

711 (1) (a) Except as provided under Subsection (1)(b):
712 (i) a licensee under this chapter may not act in the same or any directly related
713 transaction as:
714 (A) a producer for the insured or consultant; and
715 (B) producer for the insurer; and
716 (ii) a producer for the insured or consultant may not recommend or encourage the
717 purchase of insurance from or through an insurer or other producer:
718 (A) of which the producer for the insured or consultant or producer for the insured's or
719 consultant's spouse is an owner, executive, or employee; or
720 (B) to which the producer for the insured or consultant has the type of relation that a
721 material benefit would accrue to the producer for the insured or consultant or spouse as a result
722 of the purchase.
723 (b) Subsection (1)(a) does not apply if the following three conditions are met:
724 (i) Prior to performing the consulting services, the producer for the insured or
725 consultant shall disclose to the client, prominently, in writing:
726 (A) the producer for the insured's or consultant's interest as a producer for the insurer,
727 or the relationship to an insurer or other producer; and
728 (B) that as a result of those interests, the producer for the insured's or the consultant's
729 recommendations should be given appropriate scrutiny.
730 (ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing,
731 after the disclosure required under Subsection (1)(b)(i), but before performing the requested
732 services.
733 (iii) Any report resulting from requested services shall contain a copy of the disclosure
734 made under Subsection (1)(b)(i).
735 (2) A licensee under this chapter may not act as to the same client as both a producer
736 for the insurer and a producer for the insured without the client's prior written consent based on
737 full disclosure.
738 (3) Whenever a person applies for insurance coverage through a producer for the
739 insured, the producer for the insured shall disclose to the applicant, in writing, that the producer
740 for the insured is not the producer for the insurer or the potential insurer. This disclosure shall
741 also inform the applicant that the applicant likely does not have the benefit of an insurer being

742 financially responsible for the conduct of the producer for the insured.

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

745 Section 8. Section **31A-23a-501** is amended to read:

746 **31A-23a-501. Licensee compensation.**

747 (1) As used in this section:

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

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

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

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

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

758 (B) received from:

759 (I) an insurer; or

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

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

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

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

766 (c) (i) "Customer" means:

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

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

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

771 (A) an employee benefit plan; or

772 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or

773 negotiated by the producer or affiliate.

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

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

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

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

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

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

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

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

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

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

790 (b) Noncommission compensation shall be:

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

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

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

797 (d) All accounting records relating to noncommission compensation shall be
798 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

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

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

803 (ii) the producer has disclosed to the insured the existence and source of any other

804 compensation that accrues to the producer as a result of the transaction.

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

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

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

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

812 (c) The following additional noncommission compensation is authorized:

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

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

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

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

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

825 (i) a producer;

826 (ii) an affiliate of a producer; or

827 (iii) a consultant.

828 (b) Beginning January 1, 2010, in addition to any other disclosures required by this
829 section, a producer may not accept or receive any compensation from an insurer or third party
830 administrator for the placement of health care insurance unless prior to the customer's purchase
831 of health care insurance the producer:

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

835 at the time of the disclosure; and

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

837 (A) obtains the customer's signed acknowledgment that the disclosure under

838 Subsection (4)(b)(i) was made to the customer; or

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

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

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

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

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

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

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

856 ~~[(4)]~~ (5) This section does not alter the right of any licensee to recover from an insured
857 the amount of any premium due for insurance effected by or through that licensee or to charge
858 a reasonable rate of interest upon past-due accounts.

859 ~~[(5)]~~ (6) This section does not apply to bail bond producers or bail enforcement agents
860 as defined in Section 31A-35-102.

861 Section 9. Section 31A-30-102 is amended to read:

862 **Part 1. Individual and Small Employer Group**

863 **31A-30-102. Purpose statement.**

864 The purpose of this chapter is to:

- 865 (1) prevent abusive rating practices;

- 866 (2) require disclosure of rating practices to purchasers;
- 867 (3) establish rules regarding:
- 868 (a) a universal individual and small group application; and
- 869 (b) renewability of coverage;
- 870 (4) improve the overall fairness and efficiency of the individual and small group
- 871 insurance market; [~~and~~]
- 872 (5) provide increased access for individuals and small employers to health insurance[-];
- 873 and
- 874 (6) provide an employer with the opportunity to establish a defined contribution
- 875 arrangement for an employee to purchase a health benefit plan through the Internet portal
- 876 created by Section 63M-1-2504.
- 877 Section 10. Section **31A-30-103** is amended to read:
- 878 **31A-30-103. Definitions.**
- 879 As used in this chapter:
- 880 (1) "Actuarial certification" means a written statement by a member of the American
- 881 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
- 882 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,
- 883 including review of the appropriate records and of the actuarial assumptions and methods used
- 884 by the covered carrier in establishing premium rates for applicable health benefit plans.
- 885 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
- 886 through one or more intermediaries, controls or is controlled by, or is under common control
- 887 with, a specified entity or person.
- 888 (3) "Base premium rate" means, for each class of business as to a rating period, the
- 889 lowest premium rate charged or that could have been charged under a rating system for that
- 890 class of business by the covered carrier to covered insureds with similar case characteristics for
- 891 health benefit plans with the same or similar coverage.
- 892 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under
- 893 [~~Subsection~~] Section 31A-22-613.5[(2)].
- 894 (5) "Carrier" means any person or entity that provides health insurance in this state
- 895 including:
- 896 (a) an insurance company;

- 897 (b) a prepaid hospital or medical care plan;
- 898 (c) a health maintenance organization;
- 899 (d) a multiple employer welfare arrangement; and
- 900 (e) any other person or entity providing a health insurance plan under this title.
- 901 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
- 902 demographic or other objective characteristics of a covered insured that are considered by the
- 903 carrier in determining premium rates for the covered insured.
- 904 (b) "Case characteristics" do not include:
- 905 (i) duration of coverage since the policy was issued;
- 906 (ii) claim experience; and
- 907 (iii) health status.
- 908 (7) "Class of business" means all or a separate grouping of covered insureds
- 909 established under Section 31A-30-105.
- 910 (8) "Conversion policy" means a policy providing coverage under the conversion
- 911 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.
- 912 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
- 913 this chapter.
- 914 (10) "Covered individual" means any individual who is covered under a health benefit
- 915 plan subject to this chapter.
- 916 (11) "Covered insureds" means small employers and individuals who are issued a
- 917 health benefit plan that is subject to this chapter.
- 918 (12) "Dependent" means an individual to the extent that the individual is defined to be
- 919 a dependent by:
- 920 (a) the health benefit plan covering the covered individual; and
- 921 (b) Chapter 22, Part 6, Accident and Health Insurance.
- 922 (13) "Established geographic service area" means a geographical area approved by the
- 923 commissioner within which the carrier is authorized to provide coverage.
- 924 (14) "Index rate" means, for each class of business as to a rating period for covered
- 925 insureds with similar case characteristics, the arithmetic average of the applicable base
- 926 premium rate and the corresponding highest premium rate.
- 927 (15) "Individual carrier" means a carrier that provides coverage on an individual basis

928 through a health benefit plan regardless of whether:

929 (a) coverage is offered through:

930 (i) an association;

931 (ii) a trust;

932 (iii) a discretionary group; or

933 (iv) other similar groups; or

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

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

936 (a) an individual; or

937 (b) an individual with a family.

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

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

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

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

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

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

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

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

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

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

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

961 (b) A covered carrier may not have:

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

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

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

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

967 (a) is not renewable; and

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

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

973 (a) coverage is offered through:

974 (i) an association;

975 (ii) a trust;

976 (iii) a discretionary group; or

977 (iv) other similar grouping; or

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

979 (27) "Uninsurable" means an individual who:

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

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

983 (ii) has a condition of health that does not meet consistently applied underwriting
984 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)
985 and (j) for which coverage the applicant is applying.

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

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

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

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

993 **31A-30-104. Applicability and scope.**

994 (1) This chapter applies to any:

995 (a) health benefit plan that provides coverage to:

996 (i) individuals;

997 (ii) small employers; or

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

999 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
1000 31A-30-107.5.

1001 (2) This chapter applies to a health benefit plan that provides coverage to small
1002 employers or individuals regardless of:

1003 (a) whether the contract is issued to:

1004 (i) an association;

1005 (ii) a trust;

1006 (iii) a discretionary group; or

1007 (iv) other similar grouping; or

1008 (b) the situs of delivery of the policy or contract.

1009 (3) This chapter does not apply to:

1010 (a) a large employer health benefit plan, except as specifically provided in Part 2,
1011 Defined Contribution Arrangements;

1012 (b) short-term limited duration health insurance; or

1013 (c) federally funded or partially funded programs.

1014 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

1015 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
1016 return shall be treated as one carrier; and

1017 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
1018 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
1019 carriers were issued by one carrier.

1020 (b) Upon a finding of the commissioner, an affiliated carrier that is a health

1021 maintenance organization having a certificate of authority under this title may be considered to
1022 be a separate carrier for the purposes of this chapter.

1023 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
1024 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
1025 arrangements with respect to health benefit plans delivered or issued for delivery to covered
1026 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
1027 obligation or risk for the health benefit plans being retained by the ceding carrier.

1028 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
1029 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
1030 for delivery to covered insureds in this state.

1031 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
1032 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
1033 may make a written request to the commissioner for a waiver from the application of any of the
1034 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
1035 trust.

1036 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
1037 waiver if the commissioner finds that application with respect to the trust would:

1038 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
1039 and

1040 (ii) require significant modifications to one or more collective bargaining arrangements
1041 under which the trust is established or maintained.

1042 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
1043 person participates in a Taft Hartley trust as an associate member of any employee
1044 organization.

1045 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
1046 31A-30-111 apply to:

1047 (a) any insurer engaging in the business of insurance related to the risk of a small
1048 employer for medical, surgical, hospital, or ancillary health care expenses of the small
1049 employer's employees provided as an employee benefit; and

1050 (b) any contract of an insurer, other than a workers' compensation policy, related to the
1051 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the

1052 small employer's employees provided as an employee benefit.

1053 (7) The commissioner may make rules requiring that the marketing practices be
1054 consistent with this chapter for:

1055 (a) a small employer carrier;

1056 (b) a small employer carrier's agent;

1057 (c) an insurance producer; and

1058 (d) an insurance consultant.

1059 Section 12. Section **31A-30-107** is amended to read:

1060 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
1061 **nonrenewal.**

1062 (1) Except as otherwise provided in this section, a small employer health benefit plan is
1063 renewable and continues in force:

1064 (a) with respect to all eligible employees and dependents; and

1065 (b) at the option of the plan sponsor.

1066 (2) A small employer health benefit plan may be discontinued or nonrenewed:

1067 (a) for a network plan, if:

1068 (i) there is no longer any enrollee under the group health plan who lives, resides, or
1069 works in:

1070 (A) the service area of the covered carrier; or

1071 (B) the area for which the covered carrier is authorized to do business; and

1072 (ii) in the case of the small employer market, the small employer carrier applies the
1073 same criteria the small employer carrier would apply in denying enrollment in the plan under
1074 Subsection 31A-30-108(7); or

1075 (b) for coverage made available in the small or large employer market only through an
1076 association, if:

1077 (i) the employer's membership in the association ceases; and

1078 (ii) the coverage is terminated uniformly without regard to any health status-related
1079 factor relating to any covered individual.

1080 (3) A small employer health benefit plan may be discontinued if:

1081 (a) a condition described in Subsection (2) exists;

1082 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay

1083 premiums or contributions in accordance with the terms of the contract;

1084 (c) the plan sponsor:

1085 (i) performs an act or practice that constitutes fraud; or

1086 (ii) makes an intentional misrepresentation of material fact under the terms of the

1087 coverage;

1088 (d) the covered carrier:

1089 (i) elects to discontinue offering a particular small employer health benefit product

1090 delivered or issued for delivery in this state; and

1091 (ii) (A) provides notice of the discontinuation in writing:

1092 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1093 (II) at least 90 days before the date the coverage will be discontinued;

1094 (B) provides notice of the discontinuation in writing:

1095 (I) to the commissioner; and

1096 (II) at least three working days prior to the date the notice is sent to the affected plan

1097 sponsors, employees, and dependents of the plan sponsors or employees;

1098 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all

1099 other small employer health benefit products currently being offered by the small employer

1100 carrier in the market; and

1101 (D) in exercising the option to discontinue that product and in offering the option of

1102 coverage in this section, acts uniformly without regard to:

1103 (I) the claims experience of a plan sponsor;

1104 (II) any health status-related factor relating to any covered participant or beneficiary; or

1105 (III) any health status-related factor relating to any new participant or beneficiary who

1106 may become eligible for the coverage; or

1107 (e) the covered carrier:

1108 (i) elects to discontinue all of the covered carrier's small employer health benefit plans

1109 in:

1110 (A) the small employer market;

1111 (B) the large employer market; or

1112 (C) both the small employer and large employer markets; and

1113 (ii) (A) provides notice of the discontinuation in writing:

- 1114 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1115 (II) at least 180 days before the date the coverage will be discontinued;
- 1116 (B) provides notice of the discontinuation in writing:
- 1117 (I) to the commissioner in each state in which an affected insured individual is known
1118 to reside; and
- 1119 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1120 sponsors, employees, and the dependents of the plan sponsors or employees;
- 1121 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1122 market; and
- 1123 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- 1124 (4) A small employer health benefit plan may be discontinued or nonrenewed:
- 1125 (a) if a condition described in Subsection (2) exists; or
- 1126 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1127 employer contribution requirements.
- 1128 (5) A small employer health benefit plan may be nonrenewed:
- 1129 (a) if a condition described in Subsection (2) exists; or
- 1130 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1131 minimum participation requirements.
- 1132 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
1133 discontinued if after issuance of coverage the eligible employee:
- 1134 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
1135 or
- 1136 (ii) makes an intentional misrepresentation of material fact in connection with the
1137 coverage.
- 1138 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
- 1139 (i) 12 months after the date of discontinuance; and
- 1140 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1141 to reenroll.
- 1142 (c) At the time the eligible employee's coverage is discontinued under Subsection
1143 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
1144 coverage is discontinued.

1145 (d) An eligible employee may not be discontinued under this Subsection (6) because of
1146 a fraud or misrepresentation that relates to health status.

1147 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
1148 the employer:

1149 (a) with respect to coverage provided to an employer member of the association; and

1150 (b) if the small employer health benefit plan is made available by a covered carrier in
1151 the employer market only through:

1152 (i) an association;

1153 (ii) a trust; or

1154 (iii) a discretionary group.

1155 (8) A covered carrier may modify a small employer health benefit plan only:

1156 (a) at the time of coverage renewal; and

1157 (b) if the modification is effective uniformly among all plans with that product.

1158 Section 13. Section **31A-30-109** is amended to read:

1159 **31A-30-109. Health benefit plan choices.**

1160 (1) An individual carrier who offers individual coverage pursuant to Section
1161 31A-30-108;

1162 (a) shall offer in the individual market under this chapter:

1163 (i) a choice of coverage that is at least equal to or greater than basic coverage[-]; and

1164 (ii) beginning January 1, 2010, the Utah NetCare Plan described in Section

1165 31A-22-724; and

1166 (b) may offer a choice of coverage that:

1167 (i) costs less than or equal to the plan described in Subsection (1)(a)(ii); and

1168 (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

1169 (2) Beginning January 1, 2010, a small employer group carrier who offers small
1170 employer group coverage pursuant to Section 31A-30-108:

1171 (a) shall offer in the small employer group market under this part:

1172 (i) a choice of coverage that is at least equal to or greater than basic coverage; and

1173 (ii) coverage under the Utah NetCare Plan described in Section 31A-22-724; and

1174 (b) may offer in the small employer group market under this part, a choice of coverage

1175 that:

- 1176 (i) costs less than or equal to the coverage in Subsection (2)(a); and
- 1177 (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).
- 1178 (3) Nothing in this section limits the number of health benefit plans an insurer may
- 1179 offer.

1180 Section 14. Section **31A-30-112** is amended to read:

1181 **31A-30-112. Employee participation levels.**

1182 (1) (a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement
1183 used by a covered carrier in determining whether to provide coverage to a small employer,
1184 including a requirement for minimum participation of eligible employees and minimum
1185 employer contributions, shall be applied uniformly among all small employers with the same
1186 number of eligible employees applying for coverage or receiving coverage from the covered
1187 carrier.

1188 (b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require
1189 that a small employer have a minimum of two eligible employees to meet participation
1190 requirements.

1191 (2) A covered carrier may not increase a requirement for minimum employee
1192 participation or a requirement for minimum employer contribution applicable to a small
1193 employer at any time after the small employer is accepted for coverage.

1194 Section 15. Section **31A-30-201** is enacted to read:

1195 **Part 2. Defined Contribution Arrangements**

1196 **31A-30-201. Title.**

1197 This part is known as "Defined Contribution Arrangements."

1198 Section 16. Section **31A-30-202** is enacted to read:

1199 **31A-30-202. Definitions.**

1200 For purposes of this part:

1201 (1) "Defined contribution arrangement" means a defined contribution arrangement
1202 employer group health benefit plan that:

1203 (a) complies with this part; and

1204 (b) is sold through the Internet portal in accordance with Title 63M, Chapter 1, Part 25,
1205 Health System Reform Act.

1206 (2) "Health reimbursement arrangement" means an employer provided health

1207 reimbursement arrangement in which reimbursements for medical care expenses are excluded
1208 from an employee's gross income under the Internal Revenue Code.

1209 (3) "Producer" is as defined in Subsection 31A-23a-501(4)(a).

1210 (4) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies
1211 under Section 125, Internal Revenue Code which permits an employee to contribute pre-tax
1212 dollars to a health benefit plan.

1213 (5) "Small employer" is defined in Section 31A-1-301.

1214 Section 17. Section **31A-30-203** is enacted to read:

1215 **31A-30-203. Eligibility for defined contribution arrangement market --**
1216 **Enrollment.**

1217 (1) (a) Beginning January 1, 2010, an eligible small employer may choose to
1218 participate in a defined contribution arrangement.

1219 (b) Beginning January 1, 2012, an eligible large employer may choose to participate in
1220 a defined contribution arrangement.

1221 (c) Defined contribution arrangement health benefit plans are employer group health
1222 plans individually selected by an employee of an employer.

1223 (2) (a) Participating insurers shall offer to accept all eligible employees of an employer
1224 described in Subsection (1), and their dependents at the same level of benefits as anyone else
1225 who has the same health benefit plan in the defined contribution arrangement market.

1226 (b) A participating insurer may:

1227 (i) request an employer to submit a copy of the employer's quarterly wage list to
1228 determine whether the employees for whom coverage is provided or requested are bona fide
1229 employees of the employer; and

1230 (ii) deny or terminate coverage if the employer refuses to provide documentation
1231 requested under Subsection (2)(b)(i).

1232 Section 18. Section **31A-30-204** is enacted to read:

1233 **31A-30-204. Employer responsibilities -- Defined contribution arrangements.**

1234 (1) (a) (i) An employer described in Subsection 31A-30-203(1) that chooses to
1235 participate in a defined contribution arrangement may not offer a major medical health benefit
1236 plan that is not a part of the defined contribution arrangement to an employee.

1237 (ii) Subsection (1)(a)(i) does not prohibit the offer of supplemental or limited benefit

1238 policies such as dental or vision coverage, or other types of federally qualified savings accounts
1239 for health care expenses.

1240 (b) (i) To the extent permitted by the risk adjustment plan adopted under Section
1241 31A-42-202, the employer reserves the right to determine:

1242 (A) the criteria for employee eligibility, enrollment, and participation in the employer's
1243 health benefit plan; and

1244 (B) the amount of the employer's contribution to that plan.

1245 (ii) The determinations made under Subsection (1)(b) may only be changed during
1246 periods of open enrollment.

1247 (2) An employer that chooses to establish a defined contribution arrangement to
1248 provide a health benefit plan for its employees shall:

1249 (a) establish a mechanism for its employees to use pre-tax dollars to purchase a health
1250 benefit plan from the defined contribution arrangement market on the Internet portal created in
1251 Section 63M-1-2504, which may include:

1252 (i) a health reimbursement arrangement;

1253 (ii) a Section 125 Cafeteria plan; or

1254 (iii) another plan or arrangement similar to Subsection (2)(a)(i) or (ii) which is
1255 excluded or deducted from gross income under the Internal Revenue Code;

1256 (b) by November 10 of the open enrollment period:

1257 (i) inform each employee of the health benefit plan the employer has selected as the
1258 default health benefit plan for the employer group;

1259 (ii) offer each employee a choice of any of the health benefit plans available through
1260 the defined contribution arrangement market on the Internet portal; and

1261 (iii) notify the employee that the employee will be enrolled in the default health benefit
1262 plan selected by the employer and payroll deductions initiated for premium payments, unless
1263 the employee, prior to November 25 of the open enrollment period:

1264 (A) notifies the employer that the employee has selected a different health benefit plan
1265 available through the defined contribution arrangement in the Internet portal;

1266 (B) provides proof of coverage from another health benefit plan; or

1267 (C) specifically declines coverage in a health benefit plan.

1268 (3) An employer shall enroll an employee in the default health benefit plan selected by

1269 the employer if the employee does not make one of the choices described in Subsection
1270 (2)(b)(ii) prior to November 25 of the open enrollment period.

1271 (4) The employer's notice to the employee under Subsection (2)(b)(iii) shall inform the
1272 employee that the failure to act under Subsections (2)(b)(iii)(A) through (C) is considered an
1273 affirmative election under pre-tax payroll deductions for the employer to begin payroll
1274 deductions for health benefit plan premiums.

1275 Section 19. Section **31A-30-205** is enacted to read:

1276 **31A-30-205. Health benefit plans offered in the defined contribution market.**

1277 (1) An insurer who chooses to offer a health benefit plan in the defined contribution
1278 market must offer the following:

1279 (a) one health benefit plan that:

1280 (i) is a federally qualified high deductible health plan;

1281 (ii) has the lowest deductible permitted for a federally qualified high deductible health
1282 plan as adjusted by federal law; and

1283 (iii) does not exceed annual out-of-pocket maximum equal to three times the amount of
1284 the annual deductible;

1285 (b) one health benefit plan with benefits that have an actuarial value at least 15%
1286 greater than the plan described in Subsection (1)(a); and

1287 (c) beginning January 1, 2012, health benefit plans that have an actuarial value at least
1288 30% to 40% greater than the plan described in Subsection (1)(a).

1289 (2) The provisions of Subsection (1) do not limit the number of health benefit plans an
1290 insurer may offer in the defined contribution market. An insurer who offers the health benefit
1291 plans required by Subsection (1) may also offer any other health benefit plan in the defined
1292 contribution market if the health benefit plan provides benefits that are actuarially richer than
1293 the benefits required in Subsection (1)(a).

1294 Section 20. Section **31A-30-206** is enacted to read:

1295 **31A-30-206. Minimum participation and contribution levels -- Premium**
1296 **payments.**

1297 An insurer who offers a health benefit plan for which an employer has established a
1298 defined contribution arrangement under the provisions of this part:

1299 (1) shall not:

1300 (a) establish an employer minimum contribution level for the health benefit plan
1301 premium under Section 31A-30-112, or any other law; or

1302 (b) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to
1303 maintain a minimum employer contribution level;

1304 (2) shall accept premium payments for an enrollee from multiple sources through the
1305 Internet portal, including:

1306 (a) government assistance programs;

1307 (b) contributions from a Section 125 Cafeteria plan, a health reimbursement
1308 arrangement, or other qualified mechanism for pre-tax payments established by any employer
1309 of the enrollee;

1310 (c) contributions from a Section 125 Cafeteria plan, a health reimbursement
1311 arrangement, or other qualified mechanism for pre-tax payments established by an employer of
1312 a spouse or dependent of the enrollee; and

1313 (d) contributions from private sources of premium assistance; and

1314 (3) may require, as a condition of coverage, a minimum participation level for eligible
1315 employees of an employer, which for purposes of the defined contribution arrangement market
1316 may not exceed 75% participation.

1317 Section 21. Section **31A-30-207** is enacted to read:

1318 **31A-30-207. Rating and underwriting restrictions for defined contribution**
1319 **market.**

1320 (1) The rating and underwriting restrictions for the defined contribution market shall be
1321 established in accordance with the plan adopted under Chapter 42, Defined Contribution Risk
1322 Adjuster Act, and shall apply to employers who participate in the defined contribution
1323 arrangement market.

1324 (2) All insurers who participate in the defined contribution market must participate in
1325 the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster
1326 Act.

1327 Section 22. Section **31A-30-208** is enacted to read:

1328 **31A-30-208. Enrollment Periods for the Defined Contribution Market.**

1329 (1) From November 1 to November 30 of each year an insurer offering a product in the
1330 defined contribution market shall administer an open enrollment period for plans effective

1331 January 1 following the November open enrollment period, during which an eligible employee
1332 may enroll in a health benefit plan offered through the defined contribution market and may not
1333 be declined coverage.

1334 (2) (a) The period of open enrollment is the time in which an insurer may:

1335 (i) enter or exit the defined contribution market;

1336 (ii) offer new or modify existing products in the defined contribution market; or

1337 (iii) withdraw products from the defined contribution market.

1338 (b) Ninety days prior to an open enrollment period under Subsection (1), an insurer
1339 shall notify the Internet portal and the risk adjuster board created in Chapter 42, Defined
1340 Contribution Risk Adjuster Act, regarding any of the events described in Subsection (2)(a).

1341 (3) An eligible employee may enroll in a health benefit plan offered in the defined
1342 contribution market and may not be declined coverage, at a time other than the annual open
1343 enrollment period for any of the circumstances recognized as permissible under federal tax law,
1344 provided the individual does so within 63 days of the permissible circumstance.

1345 Section 23. Section **31A-42-101** is enacted to read:

1346 **CHAPTER 42. DEFINED CONTRIBUTION RISK ADJUSTER ACT**

1347 **Part 1. General Provisions**

1348 **31A-42-101. Title.**

1349 This chapter is known as the "Defined Contribution Risk Adjuster Act."

1350 Section 24. Section **31A-42-102** is enacted to read:

1351 **31A-42-102. Definitions.**

1352 As used in this chapter:

1353 (1) "Board" means the board of directors of the Utah Defined Contribution Risk
1354 Adjuster created in Section 31A-42-201.

1355 (2) "Risk adjuster" means the defined contribution risk adjustment mechanism created
1356 in Section 31A-42-201.

1357 Section 25. Section **31A-42-103** is enacted to read:

1358 **31A-42-103. Applicability and scope.**

1359 This chapter applies to a carrier as defined in Section 31A-30-103 who offers a health
1360 benefit plan in a defined contribution arrangement under Chapter 30, Part 2, Defined
1361 Contribution Arrangements.

1362 Section 26. Section 31A-42-201 is enacted to read:

1363 **Part 2. Creation of Risk Adjuster Mechanism**

1364 **31A-42-201. Creation of defined contribution market risk adjuster mechanism --**
1365 **Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.**

1366 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity
1367 within the Insurance Department.

1368 (2) (a) The risk adjuster shall be under the direction of a board of directors composed
1369 of up to nine members described in Subsection (2)(b).

1370 (b) The following directors shall be appointed by the governor with the consent of the
1371 Senate:

1372 (i) at least three, but up to five directors with actuarial experience who represent
1373 insurance carriers:

1374 (A) that are participating or have committed to participate in the defined contribution
1375 arrangement market in the state; and

1376 (B) including at least one and up to two directors who represent a carrier that has a
1377 small percentage of lives in the defined contribution market;

1378 (ii) one director who represents either an individual employee or employer participant
1379 in the defined contribution market;

1380 (iii) one director appointed by the governor to represent the Office of Consumer Health
1381 Services within the Governor's Office of Economic Development;

1382 (iv) one director representing the Public Employee's Health Benefit Program with
1383 actuarial experience, chosen by the director of the Public Employee's Health Benefit Program
1384 who shall serve as an ex officio member; and

1385 (v) the commissioner or a representative from the department with actuarial experience
1386 appointed by the commissioner, who will only have voting privileges in the event of a tie vote.

1387 (3) (a) Except as required by Subsection (3)(b), as terms of current board members
1388 appointed by the governor expire, the governor shall appoint each new member or reappointed
1389 member to a four-year term.

1390 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
1391 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
1392 board members are staggered so that approximately half of the board is appointed every two

1393 years.

1394 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
1395 appointed for the unexpired term in the same manner as the original appointment was made.

1396 (5) (a) Members who are not government employees shall receive no compensation or
1397 benefits for the members' services.

1398 (b) A state government member who is a member because of the member's state
1399 government position may not receive per diem or expenses for the member's service.

1400 (6) The board shall elect annually a chair and vice chair from its membership.

1401 (7) Six board members are a quorum for the transaction of business.

1402 (8) The action of a majority of the members of the quorum is the action of the board.

1403 Section 27. Section **31A-42-202** is enacted to read:

1404 **31A-42-202. Contents of plan.**

1405 (1) The board shall submit a plan of operation for the risk adjuster to the
1406 commissioner. The plan shall:

1407 (a) establish the methodology for implementing Subsection (2) for the defined
1408 contribution arrangement market established under Chapter 30, Part 2, Defined Contribution
1409 Arrangements;

1410 (b) establish regular times and places for meetings of the board;

1411 (c) establish procedures for keeping records of all financial transactions and for
1412 sending annual fiscal reports to the commissioner;

1413 (d) contain additional provisions necessary and proper for the execution of the powers
1414 and duties of the risk adjuster; and

1415 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
1416 Code, to pay for administrative expenses incurred.

1417 (2) (a) The plan adopted by the board for the defined contribution arrangement market
1418 shall include:

1419 (i) parameters an employer may use to designate eligible employees for the defined
1420 contribution arrangement market; and

1421 (ii) underwriting mechanisms and employer eligibility guidelines:

1422 (A) consistent with the federal Health Insurance Portability and Accountability Act;

1423 and

1424 (B) necessary to protect insurance carriers from adverse selection in the defined
1425 contribution market.

1426 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
1427 qualified individual are determined, including:

1428 (i) the identification of an initial rate for a qualified individual based on:

1429 (A) standardized age bands submitted by participating insurers; and

1430 (B) wellness incentives for the individual as permitted by federal law; and

1431 (ii) the identification of a group risk factor to be applied to the initial age rate of a
1432 qualified individual based on the health conditions of all qualified individuals in the same
1433 employer group and, for small employers, in accordance with Sections 31A-30-105 and
1434 31A-30-106.

1435 (c) The plan adopted under Subsection (2)(a) shall outline how:

1436 (i) premium contributions for qualified individuals shall be submitted to the Internet
1437 portal in the amount determined under Subsection (2)(b); and

1438 (ii) the Internet portal shall distribute premiums to the insurers selected by qualified
1439 individuals within an employer group based on each individual's health risk factor determined
1440 in accordance with the plan.

1441 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
1442 risk between insurers that:

1443 (i) identifies health care conditions subject to risk adjustment;

1444 (ii) establishes an adjustment amount for each identified health care condition;

1445 (iii) determines the extent to which an insurer has more or less individuals with an
1446 identified health condition than would be expected; and

1447 (iv) computes all risk adjustments.

1448 (e) The board may amend the plan if necessary to:

1449 (i) maintain the solvency of the defined contribution market;

1450 (ii) mitigate significant issues of risk selection; or

1451 (iii) improve the administration of the risk adjuster mechanism.

1452 Section 28. Section **31A-42-203** is enacted to read:

1453 **31A-42-203. Powers and duties of board.**

1454 (1) The board shall have the power to:

1455 (a) enter into contracts to carry out the provisions and purposes of this chapter,
1456 including, with the approval of the commissioner, contracts with persons or other organizations
1457 for the performance of administrative functions;

1458 (b) sue or be sued, including taking legal action necessary to implement and enforce
1459 the plan for risk adjustment adopted pursuant to this chapter; and

1460 (c) establish appropriate rate adjustments, underwriting policies, and other actuarial
1461 functions appropriate to the operation of the defined contribution arrangement market in
1462 accordance with Section 31A-42-202.

1463 (2) (a) The board shall prepare and submit an annual report to the department for
1464 inclusion in the department's annual market report, which shall include:

1465 (i) the expenses of administration of the risk adjuster for the defined contribution
1466 arrangement market;

1467 (ii) a description of the types of policies sold in the defined contribution arrangement
1468 market;

1469 (iii) the number of insured lives in the defined contribution arrangement market; and

1470 (iv) the number of insured lives in health benefit plans that do not include state
1471 mandates.

1472 (b) The budget for operation of the risk adjuster is subject to the approval of the board.

1473 (c) The administrative budget of the board and the commissioner under this chapter
1474 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
1475 subject to review and approval by the Legislature.

1476 (3) The board shall report to the Health Reform Task Force and to the Legislative
1477 Management Committee prior to October 1, 2009 and again prior to October 1, 2010 regarding:

1478 (a) the board's progress in developing the plan required by this chapter; and

1479 (b) the board's progress in:

1480 (i) expanding choice of plans in the defined contribution market; and

1481 (ii) expanding access to the defined contribution market in the Internet portal for large
1482 employer groups.

1483 Section 29. Section **31A-42-204** is enacted to read:

1484 **31A-42-204. Powers of commissioner.**

1485 (1) The commissioner shall, after notice and hearing, approve the plan of operation if

1486 the commissioner determines that the plan:

1487 (a) is consistent with this chapter; and

1488 (b) is a fair and reasonable administration of the risk adjuster.

1489 (2) The plan shall be effective upon the adoption of administrative rules by the
1490 commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

1491 (3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any
1492 time thereafter fails to submit proposed amendments to the plan of operation within a
1493 reasonable time after requested by the commissioner, the commissioner shall, after notice and
1494 hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

1495 (4) Rules promulgated by the commissioner shall continue in force until modified by
1496 the commissioner or until superseded by a subsequent plan of operation submitted by the board
1497 and approved by the commissioner.

1498 (5) The commissioner may designate an executive secretary from the department to
1499 provide administrative assistance to the board in carrying out its responsibilities.

1500 Section 30. Section **63M-1-2504** is amended to read:

1501 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**

1502 (1) There is created within the Governor's Office of Economic Development the Office
1503 of Consumer Health Services.

1504 (2) The office shall:

1505 (a) in cooperation with the Insurance Department, the Department of Health, and the
1506 Department of Workforce Services, and in accordance with the electronic standards developed
1507 under [Section] Sections 31A-22-635 and 63M-1-2506, create an Internet portal that:

1508 (i) is capable of providing access to private and government health insurance websites
1509 and their electronic application forms and submission procedures;

1510 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
1511 on the Internet portal by an insurer for the:

1512 (A) small employer group market;

1513 (B) the individual market; and

1514 (C) the defined contribution arrangement market; and

1515 (iii) includes information and a link to enrollment in premium assistance programs and
1516 other government assistance programs;

1517 (b) facilitate a private sector method for the collection of health insurance premium
1518 payments made for a single policy by multiple payers, including the policyholder, one or more
1519 employers of one or more individuals covered by the policy, government programs, and others
1520 by educating employers and insurers about collection services available through private
1521 vendors, including financial institutions; ~~and~~

1522 (c) assist employers with a free or low cost method for establishing mechanisms for the
1523 purchase of health insurance by employees using pre-tax dollars[-];

1524 (d) periodically convene health care providers, payers, and consumers to monitor the
1525 progress being made regarding demonstration projects for health care delivery and payment
1526 reform; and

1527 (e) report to the Business and Labor Interim Committee and the Health Reform Task
1528 Force prior to November 1, 2009 and November 1, 2010 regarding:

1529 (i) the operations of the Internet portal required by this chapter; and

1530 (ii) the progress of the demonstration projects for health care payment and delivery
1531 reform.

1532 (3) The office;

1533 (a) may not:

1534 ~~(a)~~ (i) regulate health insurers, health insurance plans, or health insurance producers;

1535 ~~(b)~~ (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

1536 ~~(c)~~ (iii) act as an appeals entity for resolving disputes between a health insurer and an
1537 insured[-]; and

1538 (b) may establish and collect a fee in accordance with Section 63J-1-303 for the
1539 transaction cost of:

1540 (i) processing an application for a health benefit plan from the Internet portal to an
1541 insurer; and

1542 (ii) accepting, processing, and submitting multiple premium payment sources.

1543 Section 31. Section **63M-1-2506** is enacted to read:

1544 **63M-1-2506. Health benefit plan information on Internet portal -- Insurer**
1545 **transparency.**

1546 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,
1547 Chapter 3, Utah Administrative Rulemaking Act, that:

- 1548 (i) establish uniform electronic standards for:
1549 (A) a health insurer to use when:
1550 (I) transmitting information to the Internet portal; or
1551 (II) receiving information from the Internet portal; and
1552 (B) facilitating the transmission and receipt of premium payments from multiple
1553 sources in the defined contribution arrangement market;
1554 (ii) designate the level of detail that would be helpful for a concise consumer
1555 comparison of the items described in Subsections (4)(a) through (d) on the Internet portal; and
1556 (iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined
1557 Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on
1558 the Internet portal with the determination of when an employer is eligible to participate in the
1559 Internet portal defined contribution market under Title 31A, Chapter 30, Part 2, Defined
1560 Contribution Arrangements.
- 1561 (b) The office shall post or facilitate the posting of:
1562 (i) the information required by this section on the Internet portal created by this part;
1563 and
1564 (ii) links to websites that provide cost and quality information from the Department of
1565 Health Data Committee or neutral entities with a broad base of support from the provider and
1566 payer communities.
- 1567 (2) A health insurer shall use the uniform electronic standards when transmitting
1568 information to the Internet portal or receiving information from the Internet portal.
- 1569 (3) (a) An insurer who participates in the defined contribution arrangement market
1570 under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans
1571 offered in that market on the Internet portal and shall comply with the provisions of this
1572 section.
- 1573 (b) An insurer who offers products under Title 31A, Chapter 30, Part 1, Individual and
1574 Small Employer Group:
- 1575 (i) shall post the basic benefit plan required by Section 31A-22-613.5 for individual
1576 and small employer group plans on the Internet portal;
1577 (ii) may publish any other health benefit plans that it offers on the Internet portal; and
1578 (iii) shall comply with the provisions of this section for every health benefit plan it

1579 posts on the Internet portal.

1580 (4) A health insurer shall provide the Internet portal with the following information for
1581 each health benefit plan submitted to the Internet portal:

1582 (a) plan design, benefits, and options offered by the health benefit plan;

1583 (b) provider networks;

1584 (c) wellness programs and incentives;

1585 (d) descriptions of prescription drug benefits, exclusions, or limitations; and

1586 (e) at the same time as information is submitted under Subsection 31A-30-208(2), the
1587 following operational measures for each health insurer that submits information to the Internet
1588 portal:

1589 (i) the percentage of claims paid by the insurer within 30 days of the date a claim is
1590 submitted to the insurer for the prior year; and

1591 (ii) the number of adverse benefit determinations by the insurer which were
1592 subsequently overturned on independent review under Section 31A-22-629 as a percentage of
1593 total claims paid by the insurer for the prior year.

1594 (5) The Insurance Department shall post on the Internet portal the Insurance
1595 Department's solvency rating for each insurer who posts a health benefit plan on the Internet
1596 portal. The solvency rating for each carrier shall be based on methodology established by the
1597 Insurance Department by administrative rule and shall be updated each calendar year.

1598 (6) The commissioner may request information from an insurer under Section
1599 31A-22-613.5 to verify the data submitted to the Internet portal under this section.

1600 (7) A health insurer shall accept and process an application for a health benefit plan
1601 from the Internet portal in accordance with Section 31A-22-635.

1602 **Section 32. Health Reform Task Force -- Creation -- Membership -- Interim rules**
1603 **followed -- Compensation -- Staff.**

1604 (1) There is created the Health Reform Task Force consisting of the following 11
1605 members:

1606 (a) four members of the Senate appointed by the president of the Senate, no more than
1607 three of whom may be from the same political party; and

1608 (b) seven members of the House of Representatives appointed by the speaker of the
1609 House of Representatives, no more than five of whom may be from the same political party.

1610 (2) (a) The president of the Senate shall designate a member of the Senate appointed
1611 under Subsection (1)(a) as a co-chair of the committee.

1612 (b) The speaker of the House of Representatives shall designate a member of the House
1613 of Representatives appointed under Subsection (1)(b) as a co-chair of the committee.

1614 (3) In conducting its business, the committee shall comply with the rules of legislative
1615 interim committees.

1616 (4) Salaries and expenses of the members of the committee shall be paid in accordance
1617 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
1618 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
1619 Sessions.

1620 (5) The Office of Legislative Research and General Counsel shall provide staff support
1621 to the committee.

1622 Section 33. **Duties -- Interim report.**

1623 (1) The committee shall review and make recommendations on the following issues:

1624 (a) the state's progress in implementing the strategic plan for health system reform as
1625 described in Section 63M-1-2505;

1626 (b) the implementation of statewide demonstration projects to provide systemwide
1627 aligned incentives for the appropriate delivery of and payment for health care;

1628 (c) the development of the defined contribution arrangement market and the plan
1629 developed by the risk adjuster board for implementation by January 1, 2012, including:

1630 (i) increased selection of health benefit plans in the defined contribution market;

1631 (ii) participation by large employer groups in the defined contribution market; and

1632 (iii) risk allocation in the defined contribution market;

1633 (d) the operations of the Internet portal, including:

1634 (i) insurer participation in the Internet portal and the defined contribution market;

1635 (ii) whether the consumer transparency on the Internet portal provides adequate

1636 information for comparison of health benefit plans and provider cost and quality;

1637 (iii) the number of employers participating in the Internet portal; and

1638 (iv) the number of insured lives through the Internet portal;

1639 (e) the effect of permitting insurers in the state to offer health benefit plans that are not

1640 subject to most state mandates on:

- 1641 (i) lowering the cost of health benefit plans; and
- 1642 (ii) increasing access to health benefit plans;
- 1643 (f) mechanisms to increase transparency in the market, including:
- 1644 (i) developing measurements and methodology for insurers to provide medical loss
- 1645 ratios as a percentage of premiums; and
- 1646 (ii) administrative overhead as a percentage of total revenue;
- 1647 (g) the implementation and effectiveness of insurer wellness programs and incentives,
- 1648 including outcome measures for the programs; and
- 1649 (h) pursue clarification from the U.S. Department of Labor regarding whether the
- 1650 federal Health Insurance Portability and Accountability Act, federal ERISA laws, and the
- 1651 Internal Revenue Code will permit an employer to offer pre-tax income to an individual for the
- 1652 purchase of a health benefit policy in the defined contribution market and allow the individual
- 1653 to purchase a health benefit policy that:
- 1654 (i) is owned by the individual, separate from the employer group plan; and
- 1655 (ii) is not subject to the employment relationship with the employer and is therefore
- 1656 fully portable.
- 1657 (2) A final report, including any proposed legislation shall be presented to the Business
- 1658 and Labor Interim Committee before November 30, 2009.

1659 Section 34. **Appropriation.**

1660 There is appropriated from the General Fund for fiscal year 2009-10 only:

- 1661 (1) \$12,000 to the Senate to pay for the compensation and expenses of senators on the
- 1662 committee; and
- 1663 (2) \$20,000 to the House of Representatives to pay for the compensation and expenses
- 1664 of representatives on the committee.

1665 Section 35. **Repeal date.**

1666 The Health System Reform Task Force created in Sections 32 and 33 of this bill is

1667 repealed December 30, 2009.

Legislative Review Note
as of 2-6-09 1:39 PM

Office of Legislative Research and General Counsel

H.B. 188 - Health System Reform - Insurance Market

Fiscal Note

2009 General Session
State of Utah

State Impact

Enactment of this bill will appropriate from the General Fund \$32,000 one-time in FY 2010. It will further require an on-going appropriation of Dedicated Credit of \$70,000 for FY 2010 and FY 2011. Additional costs may be incurred in 2012 for actuarial services.

	<u>2009</u> <u>Approp.</u>	<u>2010</u> <u>Approp.</u>	<u>2011</u> <u>Approp.</u>	<u>2009</u> <u>Revenue</u>	<u>2010</u> <u>Revenue</u>	<u>2011</u> <u>Revenue</u>
General Fund, One-Time	\$0	\$32,000	\$0	\$0	\$0	\$0
Dedicated Credits	\$0	\$70,000	\$70,000	\$0	\$0	\$0
Total	\$0	\$102,000	\$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 participation in reform efforts.
