

**HEALTH SYSTEM REFORM AMENDMENTS**

2010 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: David Clark**

Senate Sponsor: Wayne L. Niederhauser

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**LONG TITLE**

**General Description:**

This bill amends provisions related to health system reform for the insurance market, health care providers, the Health Code, and the Office of Consumer Health Services.

**Highlighted Provisions:**

This bill:

▶ provides access to the Department of Health's all payer database, for limited purposes, to the Insurance Department's health care delivery and health care payment reform demonstration project, and for the risk adjusting mechanism of the defined contribution insurance market;

▶ authorizes the all payer database to analyze the data it collects to provide consumer awareness of costs and transparency in the health care market including:

- reports on geographic variances in medical costs; and
- cost increases for health care;

▶ clarifies the restrictions and protections for identifiable health information;

**H→ ▶ requires health care providers to post prices for patients; ←H**

▶ consolidates statutory language requiring insurance department reports concerning the health insurance market;

▶ makes technical and clarifying amendments to the price and value comparison of health benefit plans;

**H→ ▶ amends the amount of excess fees from the department that will be treated as free revenue; ←H**

▶ requires the insurance commissioner to convene a group to develop a method of comparing health insurers' claims denial, and other information that would help a

H.B. 294



28 consumer compare the value of health plans, and requires an administrative rule to implement  
29 the transparency reports;

30 ▶ instructs the Insurance Department to continue its work with the Office of  
31 Consumer Health Services and the Department of Health to develop additional  
32 demonstration projects for health care delivery and payment reform and to apply for  
33 available grants to implement and expand the demonstration projects;

34 ▶ makes a technical amendment to the health plans an insurer may offer after July 1,  
35 2012;

36 ▶ requires the Insurance Department to:  
37 • convene a group to simplify the uniform health insurance application and  
38 decrease the number of questions; and

39 • develop a uniform waiver of coverage form;

40 ▶ amends group and blanket conversion coverage related to NetCare;

41 ▶ creates ongoing monthly enrollment for employers in the defined contribution  
42 market and makes conforming amendments;

43 ▶ allows a pilot program for a limited number of large employer groups to enter the  
44 defined contribution market by January 1, 2011;

45 ▶ requires an insurer in the defined contribution market to offer a choice of health  
46 benefit plans that vary in actuarial value as follows:

47 • the basic benefit plan;

48 • one plan that has an actuarial value that is at least 15% higher than the actuarial  
49 value of the basic benefit plan; and

50 • one plan that is a federally qualified high deductible plan with a \$5,000  
51 deductible;

52 ▶ allows an insurer in the defined contribution market to offer:

53 • any other health benefit plan that has a greater actuarial value than the actuarial  
54 value of the basic benefit plan; and

55 • any other health benefit plan that has an actuarial value that is no less than the  
56 actuarial value of the \$5,000 high deductible plan;

57 ▶ gives carriers the option to participate in the defined contribution market on the  
58 Health Insurance Exchange by offering defined contribution products or defined

59 benefit products on the exchange;

60       ▶ provides that a carrier that does not choose to participate in the Health Insurance  
61 Exchange by January 1, 2011 may not participate in the exchange until January 1,  
62 2013;

63       ▶ allows small employers the choice of selecting insurance products in the Health  
64 Insurance Exchange or in the traditional market outside of the exchange;

65       ▶ permits a carrier to offer defined benefit products in the traditional market outside  
66 of the Health Insurance Exchange if the carrier uses the same rating and  
67 underwriting practices in the defined benefit market and the Health Insurance  
68 Exchange so that rating practices do not favor one market over the other market;

69       ▶ prohibits insurers in the defined contribution market from treating renewing groups  
70 as new business, subject to premium rate increases, based on the employer's move  
71 from the traditional market into a defined benefit or defined contribution plan in the  
72 Health Insurance Exchange;

73       ▶ creates a procedure for a producer to be appointed as a producer for the defined  
74 contribution market;

75       ▶ requires an insurer to obtain the Insurance Department's approval to use a class of  
76 businesses for underwriting purposes;

77       ▶ effective January 1, 2011, modifies underwriting and rating practices in the small  
78 group market, in and out of the exchange;

79       ▶ amends provisions related to small employer group rating practices and individual  
80 rating practices;

81       ▶ makes amendments to the defined contribution risk adjuster to incorporate large  
82 groups into the risk adjuster;

83       ▶ effective January 1, 2013, imposes a risk adjuster mechanism on the small group  
84 market inside and outside of the Health Insurance Exchange;

85       ▶ requires health care providers to give consumers information about prices;

86       ▶ requires the Health Insurance Exchange to:

87           • create an advisory board of appointed producers and consumers; and  
88           • establish the electronic standards for delivering the uniform health insurance  
89 application;

90           ▶ clarifies the type of information that an insurer must submit to the Health Insurance  
91 Exchange and to the Insurance Department; and

92           ▶ re-authorizes the Health System Reform Task Force for one year.

93 **Monies Appropriated in this Bill:**

94           None

95 **Other Special Clauses:**

96           This bill provides an effective date.

97 **Utah Code Sections Affected:**

98 AMENDS:

99           **26-1-37**, as enacted by Laws of Utah 2008, Chapter 379

100           **26-33a-106.1**, as enacted by Laws of Utah 2007, Chapter 29

101           **26-33a-109**, as enacted by Laws of Utah 1990, Chapter 305

102           **31A-2-201**, as last amended by Laws of Utah 2008, Chapter 382

102a       **H→ 31A-3-304 (Effective 07/01/10), as last amended by Laws of Utah 2009, Chapter 183 ←H**

103           **31A-22-613.5**, as last amended by Laws of Utah 2009, Chapter 12

104           **31A-22-614.6**, as enacted by Laws of Utah 2009, Chapter 11

105           **31A-22-618.5**, as enacted by Laws of Utah 2009, Chapter 12

106           **31A-22-625**, as last amended by Laws of Utah 2008, Chapters 345 and 382

107           **31A-22-635**, as enacted by Laws of Utah 2008, Chapter 383

108           **31A-22-723**, as last amended by Laws of Utah 2009, Chapter 12

109           **31A-30-103**, as last amended by Laws of Utah 2009, Chapter 12

110           **31A-30-105**, as last amended by Laws of Utah 1995, Chapter 321

111           **31A-30-106**, as last amended by Laws of Utah 2008, Chapters 382, 383, and 385

112           **31A-30-106.5**, as last amended by Laws of Utah 2001, Chapter 116

113           **31A-30-202**, as enacted by Laws of Utah 2009, Chapter 12

114           **31A-30-203**, as enacted by Laws of Utah 2009, Chapter 12

115           **31A-30-204**, as enacted by Laws of Utah 2009, Chapter 12

116           **31A-30-205**, as enacted by Laws of Utah 2009, Chapter 12

117           **31A-30-207**, as enacted by Laws of Utah 2009, Chapter 12

118           **31A-42-102**, as enacted by Laws of Utah 2009, Chapter 12

119           **31A-42-103**, as enacted by Laws of Utah 2009, Chapter 12

120           **31A-42-201**, as enacted by Laws of Utah 2009, Chapter 12

121 31A-42-202, as enacted by Laws of Utah 2009, Chapter 12

121a **§→ 63I-1-231, as renumbered and amended by Laws of Utah 2008, Chapter 382 ←§**

122 63I-2-231, as last amended by Laws of Utah 2009, Chapter 11

123 63M-1-2504, as last amended by Laws of Utah 2009, Chapter 12

124 63M-1-2506, as enacted by Laws of Utah 2009, Chapter 12

125 ENACTS:

126 26-21-26, Utah Code Annotated 1953

127 31A-2-201.2, Utah Code Annotated 1953

128 31A-30-106.1, Utah Code Annotated 1953

129 31A-30-202.5, Utah Code Annotated 1953

130 31A-30-209, Utah Code Annotated 1953

131 31A-42a-101, Utah Code Annotated 1953

132 31A-42a-102, Utah Code Annotated 1953

133 31A-42a-103, Utah Code Annotated 1953

134 31A-42a-201, Utah Code Annotated 1953

135 31A-42a-202, Utah Code Annotated 1953

136 31A-42a-203, Utah Code Annotated 1953

137 31A-42a-204, Utah Code Annotated 1953

137a **Ĥ→ 58-5a-307, Utah Code Annotated 1953 ←Ĥ**

138 58-31b-802, Utah Code Annotated 1953

139 58-67-804, Utah Code Annotated 1953

140 58-68-804, Utah Code Annotated 1953

141 58-69-806, Utah Code Annotated 1953

141a **Ĥ→ 58-73-603, Utah Code Annotated 1953 ←Ĥ**

142 REPEALS AND REENACTS:

143 31A-30-208, as enacted by Laws of Utah 2009, Chapter 12

144 **Uncodified Material Affected:**

145 ENACTS UNCODIFIED MATERIAL

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

148 Section 1. Section 26-1-37 is amended to read:

149 **26-1-37. Duty to establish standards for the electronic exchange of clinical health**  
150 **information.**

151 (1) For purposes of this section:

152 (a) "Affiliate" means an organization that directly or indirectly through one or more  
153 intermediaries controls, is controlled by, or is under common control with another  
154 organization.

155 (b) "Clinical health information" shall be defined by the department by administrative  
156 rule adopted in accordance with Subsection (2).

157 (c) "Electronic exchange":

158 (i) includes:

159 (A) the electronic transmission of clinical health data via Internet or extranet; and

160 (B) physically moving clinical health information from one location to another using  
161 magnetic tape, disk, or compact disc media; and

162 (ii) does not include exchange of information by telephone or fax.

163 (d) "Health care provider" means a licensing classification that is either:

164 (i) licensed under Title 58, Occupations and Professions, to provide health care; or

165 (ii) licensed under Chapter 21, Health Care Facility Licensing and Inspection Act.

166 (e) "Health care system" shall include:

167 (i) affiliated health care providers;

168 (ii) affiliated third party payers; and

169 (iii) other arrangement between organizations or providers as described by the  
170 department by administrative rule.

171 (f) "Qualified network" means an entity that:

172 (i) is a non-profit organization;

173 (ii) is accredited by the Electronic Healthcare Network Accreditation Commission, or  
174 another national accrediting organization recognized by the department; and

175 (iii) performs the electronic exchange of clinical health information among multiple  
176 health care providers not under common control, multiple third party payers not under common  
177 control, the department, and local health departments.

178 [~~f~~] (g) "Third party payer" means:

179 (i) all insurers offering health insurance who are subject to Section 31A-22-614.5; and

180 (ii) the state Medicaid program.

181 (2) (a) In addition to the duties listed in Section 26-1-30, the department shall, in  
182 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

183 (i) define:

184 (A) "clinical health information" subject to this section; and

185 (B) "health system arrangements between providers or organizations" as described in  
186 Subsection (1)(e)(iii); and

187 (ii) adopt standards for the electronic exchange of clinical health information between  
188 health care providers and third party payers that are ~~[in compliance with]~~ for treatment,  
189 payment, health care operations, or public health reporting, as provided for in 45 C.F.R. Parts  
190 160, 162, and 164, Health Insurance Reform: Security Standards.

191 (b) The department shall coordinate its rule making authority under the provisions of  
192 this section with the rule making authority of the Insurance Department under Section  
193 31A-22-614.5. The department shall establish procedures for developing the rules adopted  
194 under this section, which ensure that the Insurance Department is given the opportunity to  
195 comment on proposed rules.

196 (3) (a) Except as provided in Subsection (3)~~(b)~~(e), a health care provider or third  
197 party payer in Utah is required to use the standards adopted by the department under the  
198 provisions of Subsection (2) if the health care provider or third party payer elects to engage in  
199 an electronic exchange of clinical health information with another health care provider or third  
200 party payer.

201 (b) A health care provider or third party payer may disclose information to the  
202 department or a local health department, by electronic exchange of clinical health information,  
203 as permitted by Subsection 45 C.F.R. 164.512(b).

204 (c) When functioning in its capacity as a health care provider or payer, the department  
205 or a local health department may disclose clinical health information by electronic exchange to  
206 another health care provider or third party payer.

207 (d) An electronic exchange of clinical health information by a health care provider, a  
208 third party payer, the department, or a local health department is a disclosure for treatment,  
209 payment, or health care operations if it complies with Subsection (3)(a) or (c) and is for  
210 treatment, payment, or health care operations, as those terms are defined in 45 C.F.R. Parts  
211 160, 162, and 164.

212 ~~(b)~~ (e) A health care provider or third party payer is not required to use the standards  
213 adopted by the department under the provisions of Subsection (2) if the health care provider or

214 third party payer engage in the electronic exchange of clinical health information within a  
215 particular health care system.

216 (4) Nothing in this section shall limit the number of networks eligible to engage in the  
217 electronic data interchange of clinical health information using the standards adopted by the  
218 department under Subsection (2)(a)(ii).

219 (5) The department, a local health department, a health care provider, a third party  
220 payer, or a qualified network is not subject to civil liability for a disclosure of clinical health  
221 information if the disclosure is in accordance both with Subsection (3)(a) and with Subsection  
222 (3)(b), 3(c), or 3(d).

223 (6) Within a qualified network, information generated or disclosed in the electronic  
224 exchange of clinical health information is not subject to discovery, use, or receipt in evidence  
225 in any legal proceeding of any kind or character.

226 [~~5~~] (7) The department shall report on the use of the standards for the electronic  
227 exchange of clinical health information to the legislative Health and Human Services Interim  
228 Committee no later than October 15[~~, 2008 and no later than every October 15th thereafter~~] of  
229 each year. The report shall include publicly available information concerning the costs and  
230 savings for the department, third party payers, and health care providers associated with the  
231 standards for the electronic exchange of clinical health records.

232 Section 2. Section ~~26-21-26~~ is enacted to read:

233 **26-21-26. Consumer access to facility charges.**

234 Beginning January 1, 2011, a health care facility licensed under this chapter shall, when  
235 requested by a consumer:

236 (1) make a list of prices charged by the facility available for the consumer that includes  
237 the facility's:

238 (a) in-patient procedures;

239 (b) out-patient procedures;

240 (c) the 50 most commonly prescribed drugs in the facility;

241 (d) imaging services; and

242 (e) implants; and

243 (2) provide the consumer with information regarding any discounts the facility  
244 provides for:

245 (a) charges for services not covered by insurance; or

246 (b) prompt payment of billed charges.

247 Section 3. Section **26-33a-106.1** is amended to read:

248 **26-33a-106.1. Health care cost and reimbursement data.**

249 (1) (a) The committee shall, as funding is available, establish an advisory panel to  
250 advise the committee on the development of a plan for the collection and use of health care  
251 data pursuant to Subsection 26-33a-104(6) and this section.

252 (b) The advisory panel shall include:

253 (i) the chairman of the Utah Hospital Association;

254 (ii) a representative of a rural hospital as designated by the Utah Hospital Association;

255 (iii) a representative of the Utah Medical Association;

256 (iv) a physician from a small group practice as designated by the Utah Medical

257 Association;

258 (v) two representatives [~~from the Utah Health Insurance Association~~] who are health  
259 insurers, appointed by the committee;

260 (vi) a representative from the Department of Health as designated by the executive  
261 director of the department;

262 (vii) a representative from the committee;

263 (viii) a consumer advocate appointed by the committee;

264 (ix) a member of the House of Representatives appointed by the speaker of the House;

265 and

266 (x) a member of the Senate appointed by the president of the Senate.

267 (c) The advisory panel shall elect a chair from among its members, and shall be staffed  
268 by the committee.

269 (2) (a) The committee shall, as funding is available[-];

270 (i) establish a plan for collecting data from data suppliers, as defined in Section  
271 26-33a-102, to determine measurements of cost and reimbursements for risk adjusted episodes  
272 of health care[-];

273 (ii) assist the demonstration projects implemented by the Insurance Department  
274 pursuant to Section 31A-22-614.6, with access to cost data, reimbursement data, care process  
275 data, and provider service data necessary for the demonstration projects' research, statistical

276 analysis, and quality improvement activities:

277 (A) notwithstanding Subsection 26-33a-108(1) and Section 26-33a-109;

278 (B) contingent upon approval by the committee; and

279 (C) subject to a contract between the department and the entity providing analysis for  
280 the demonstration project;

281 (iii) share data regarding insurance claims with insurers participating in the defined  
282 contribution market created in Title 31A, Chapter 30, Part 2, Defined Contribution  
283 Arrangements, only to the extent necessary for:

284 (A) renewals of policies in the defined contribution arrangement market; and

285 (B) risk adjusting in the defined contribution arrangement market; and

286 (iv) assist the Legislature and the public with awareness of, and the promotion of,  
287 transparency in the health care market by reporting on:

288 (A) geographic variances in medical care and costs as demonstrated by data available  
289 to the committee; and

290 (B) rate and price increases by health care providers:

291 (I) that exceed the consumer price index - medical as provided by the United States  
292 Bureau of Labor statistics;

293 (II) as calculated yearly from June to June; and

294 (III) as demonstrated by data available to the committee.

295 (b) The plan adopted under this Subsection (2) shall include:

296 (i) the type of data that will be collected;

297 (ii) how the data will be evaluated;

298 (iii) how the data will be used;

299 (iv) the extent to which, and how the data will be protected; and

300 (v) who will have access to the data.

301 Section 4. Section **26-33a-109** is amended to read:

302 **26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.**

303 (1) The committee may not disclose any identifiable health data unless:

304 [(+) (a) the individual has [consented to] authorized the disclosure; or

305 [(2) (b) the disclosure [is to any organization that has an institutional review board,]

306 complies with the provisions of this section.

307 (2) The committee shall consider the following when responding to a request for  
 308 disclosure of information that may include identifiable health data:

309 (a) whether the request comes from a person after that person has received approval to  
 310 do the specific research and statistical work from an institutional review board; and

311 (b) whether the requesting entity complies with the provisions of Subsection (3).

312 (3) A request for disclosure of information that may include identifiable health data  
 313 shall:

314 (a) be for a specified period[;]; or

315 (b) be solely for bona fide research and statistical purposes[;] as determined in  
 316 accordance with administrative rules adopted by the department [~~rules, and~~], which shall  
 317 require:

318 (i) the requesting entity to demonstrate to the department [~~determines~~] that the data is  
 319 required for the research and statistical purposes proposed by the requesting entity; and

320 (ii) the requesting [~~individual or organization enters~~] entity to enter into a written  
 321 agreement satisfactory to the department to protect the data in accordance with this chapter or  
 322 other applicable law [~~and not permit further disclosure~~].

323 (4) A person accessing identifiable health data pursuant to Subsection (3) may not  
 324 further disclose the identifiable health data:

325 (a) without prior approval of the department[~~Any~~]; and

326 (b) unless the identifiable health data is disclosed [~~shall be~~] or identified by control  
 327 number only.

328 Section 5. Section **31A-2-201** is amended to read:

329 **31A-2-201. General duties and powers.**

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

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

334 (3) (a) The commissioner may make rules to implement the provisions of this title  
 335 according to the procedures and requirements of Title 63G, Chapter 3, Utah Administrative  
 336 Rulemaking Act.

337 (b) In addition to the notice requirements of Section 63G-3-301, the commissioner

338 shall provide notice under Section 31A-2-303 of hearings concerning insurance department  
339 rules.

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

343 (i) is in writing; and

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

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

347 (5) (a) The commissioner may hold informal adjudicative proceedings and public  
348 meetings, for the purpose of:

349 (i) investigation;

350 (ii) ascertainment of public sentiment; or

351 (iii) informing the public.

352 (b) An effective rule or order may not result from informal hearings and meetings  
353 unless the requirement of a hearing under this section is satisfied.

354 (6) The commissioner shall inquire into violations of this title and may conduct any  
355 examinations and investigations of insurance matters, in addition to examinations and  
356 investigations expressly authorized, that the commissioner considers proper to determine:

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

358 (b) to secure information useful in the lawful administration of this title.

359 ~~[(7)(a) Each year, the commissioner shall:]~~

360 ~~[(i) conduct an evaluation of the state's health insurance market;]~~

361 ~~[(ii) report the findings of the evaluation to the Health and Human Services Interim  
362 Committee before October 1; and]~~

363 ~~[(iii) publish the findings of the evaluation on the department website.]~~

364 ~~[(b) The evaluation required by Subsection (7)(a) shall:]~~

365 ~~[(i) analyze the effectiveness of the insurance regulations and statutes in promoting a  
366 healthy, competitive health insurance market that meets the needs of Utahns by assessing such  
367 things as:]~~

368 ~~[(A) the availability and marketing of individual and group products;]~~

- 369 ~~[(B) rate charges;]~~  
 370 ~~[(C) coverage and demographic changes;]~~  
 371 ~~[(D) benefit trends;]~~  
 372 ~~[(E) market share changes; and]~~  
 373 ~~[(F) accessibility;]~~  
 374 ~~[(ii) assess complaint ratios and trends within the health insurance market, which~~  
 375 ~~assessment shall integrate complaint data from the Office of Consumer Health Assistance~~  
 376 ~~within the department;]~~  
 377 ~~[(iii) contain recommendations for action to improve the overall effectiveness of the~~  
 378 ~~health insurance market, administrative rules, and statutes; and]~~  
 379 ~~[(iv) include claims loss ratio data for each insurance company doing business in the~~  
 380 ~~state.]]~~  
 381 ~~[(c) When preparing the evaluation required by this Subsection (7), the commissioner~~  
 382 ~~may seek the input of insurers, employers, insured persons, providers, and others with an~~  
 383 ~~interest in the health insurance market.]]~~

384 Section 6. Section **31A-2-201.2** is enacted to read:

385 **31A-2-201.2. Evaluation of Health Insurance Market.**

386 (1) Each year the commissioner shall:

387 (a) conduct an evaluation of the state's health insurance market;

388 (b) report the findings of the evaluation to the Health and Human Services Interim

389 Committee before October 1 of each year; and

390 (c) publish the findings of the evaluation on the department website.

391 (2) The evaluation required by this section shall:

392 (a) analyze the effectiveness of the insurance regulations and statutes in promoting a  
 393 healthy, competitive health insurance market that meets the needs of the state, and includes an  
 394 analysis of:

395 (i) the availability and marketing of individual and group products;

396 (ii) rate changes;

397 (iii) coverage and demographic changes;

398 (iv) benefit trends;

399 (v) market share changes; and

400 (vi) accessibility;

401 (b) assess complaint ratios and trends within the health insurance market, which  
 402 assessment shall include complaint data from the Office of Consumer Health Assistance within  
 403 the department;

404 (c) contain recommendations for action to improve the overall effectiveness of the  
 405 health insurance market, administrative rules, and statutes; and

406 (d) include claims loss ratio data for each health insurance company doing business in  
 407 the state.

408 (3) When preparing the evaluation required by this section, the commissioner shall  
 409 include a report of:

410 (a) the types of health benefit plans sold in the Health Insurance Exchange created in  
 411 Section 63M-1-2504;

412 (b) the number of insurers participating in the defined contribution arrangement health  
 413 benefit plans in the Health Insurance Exchange;

414 (c) the number of employers and covered lives in the defined contribution arrangement  
 415 market in the Health Insurance Exchange; and

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

418 (4) When preparing the evaluation and report required by this section, the  
 419 commissioner may seek the input of insurers, employers, insured persons, providers, and others  
 420 with an interest in the health insurance market.

421 (5) The commissioner may adopt administrative rules for the purpose of collecting the  
 422 data required by this section, taking into account the business confidentiality of the insurers.

423 (6) Records submitted to the commissioner under this section shall be maintained by  
 424 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
 425 Access and Management Act.

425a **H→ Section 7. Section 31A-3-304 (Effective 07/01/10) is amended to read:**

425b **31A-3-304 (Effective 07/01/10). Annual fees -- Other taxes or fees prohibited.**

425c **(1) (a) A captive insurance company shall pay an annual fee imposed under this section to**  
 425d **obtain or**  
 425e **renew a certificate of authority.**

425f **(b) The commissioner shall:**

425g **(i) determine the annual fee pursuant to Sections 31A-3-103 and 63J-1-504; and**

425h **(ii) consider whether the annual fee is competitive with fees imposed by other states on captive**  
 425i **insurance companies.**

425j **(2) A captive insurance company that fails to pay the fee required by this section is subject to**

425k the relevant sanctions of this title.

425l (3) (a) Except as provided in Subsection (3)(b) and notwithstanding Title 59, Chapter 9,  
425m Taxation of

425n Admitted Insurers, the fee provided for in this section constitutes the sole tax or fee under the laws of  
425o this

425p state that may be otherwise levied or assessed on a captive insurance company, and no other  
425q occupation tax

425r or other tax or fee may be levied or collected from a captive insurance company by the state or a  
425s county, city,

425t or municipality within this state.

425u (b) Notwithstanding Subsection (3)(a), a captive insurance company is subject to real and  
425v personal  
425w property taxes.

425x (4) A captive insurance company shall pay the fee imposed by this section to the department  
425y by  
425z March 31 of each year.

425aa (5) (a) The funds received pursuant to Subsection (2) shall be deposited into the General Fund  
425ab as a  
425ac dedicated credit to be used by the department to:

425ad (i) administer and enforce Chapter 37, Captive Insurance Companies Act; and

425ae (ii) promote the captive insurance industry in Utah.

425af (b) At the end of each fiscal year, funds received by the department in excess of [~~\$750,000~~]  
425ag \$600,000 shall be treated as free revenue in the General Fund. ←H

426 Section 7. Section ~~31A-22-613.5~~ is amended to read:

427 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**  
428 **Care Plan.**

429 (1) (a) [~~Except as provided in Subsection (1)(b), this~~] This section applies to all health  
430 [~~insurance policies and health maintenance organization contracts~~] benefit plans.

431 (b) Subsection (2) applies to:

432 (i) all [~~health insurance policies and health maintenance organization contracts~~] health  
433 benefit plans; and

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

435 (2) (a) The commissioner shall promote informed consumer behavior and responsible  
436 [~~health insurance and~~] health benefit plans by requiring an insurer issuing [~~health insurance~~  
437 ~~policies or health maintenance organization contracts~~] a health benefit plan to:

438 (i) provide to all enrollees, prior to enrollment in the health benefit plan [~~or health~~  
439 ~~insurance policy~~], written disclosure of:

440 [(i)] (A) restrictions or limitations on prescription drugs and biologics including ~~H→~~ :

440a (I) ~~←H~~ the use

441 of a formulary ~~H→~~ [~~and~~] ;

441a (II) co-payments and deductibles for prescription drugs; and

441b (III) requirements for ~~←H~~ generic substitution;

442 [(ii)] (B) coverage limits under the plan; and

443 [(iii)] (C) any limitation or exclusion of coverage including:

444 [(A)] (I) a limitation or exclusion for a secondary medical condition related to a  
445 limitation or exclusion from coverage; and

446 [(B)] (II) [~~beginning July 1, 2009,~~] easily understood examples of a limitation or  
447 exclusion of coverage for a secondary medical condition[-]; and

448 (ii) provide the commissioner with:

449 (A) the information described in Subsections 63M-1-2506(3) through (6) in the  
450 standardized electronic format required by Subsection 63M-1-2506(1); and

451 (B) information regarding insurer transparency in accordance with Subsection (5) of  
452 this section.

453 (b) [~~In addition to the requirements of Subsections (2)(a), (d), and (e) an insurer~~  
454 ~~described in Subsection (2)(a)~~] An insurer shall ~~H→~~ [~~file~~] provide ~~←H~~ the

454a ~~H→~~ [~~written~~] ~~←H~~ disclosure required by [~~this~~]

455 Subsection (2)(a)(i) [~~to~~] ~~H→~~ [~~with the commissioner~~] ~~←H~~ :

456 (i) ~~H→~~ in writing to the commissioner:

456a (A) ~~←H~~ upon commencement of operations in the state; and

457 ~~H→~~ [(ii)] (B) ~~←H~~ anytime the insurer amends any of the following described in Subsection

457a (2)(a)(i):

458 ~~H→~~ [(A)] (I) ~~←H~~ treatment policies;

459 ~~H→~~ [(B)] (II) ~~←H~~ practice standards;

460 ~~H→~~ [(C)] (III) ~~←H~~ restrictions;

461 ~~H→~~ [(D)] (IV) ~~←H~~ coverage limits of the insurer's health benefit plan or health insurance

461a policy; or

462 ~~H~~→ [(E)] (V) ←~~H~~ limitations or exclusions of coverage including a limitation or exclusion  
 462a for a  
 463 secondary medical condition related to a limitation or exclusion of the insurer's health  
 464 insurance plan ~~H~~→ ; and  
 464a (ii) to the enrollee, notice of the change in prescription drug coverage under Subsection  
 464b (2)(a)(i)(A):  
 464c (A) either in writing or through the insurer's website; and  
 464d (B) at least 30 days prior to the date of the implementation of the change in  
 464e prescription drug coverage, or as soon as reasonably possible ←~~H~~ .  
 465 [~~(c)~~ The commissioner may adopt rules to implement the disclosure requirements of  
 466 this Subsection (2), taking into account:]  
 467 [(i) business confidentiality of the insurer;]  
 468 [(ii) definitions of terms;]  
 469 [(iii) the method of disclosure to enrollees; and]  
 470 [(iv) limitations and exclusions.]  
 471 [~~(d)~~ (c) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make  
 472 available to prospective enrollees and maintain evidence of the fact of the disclosure of:  
 473 (i) the drugs included;  
 474 (ii) the patented drugs not included;  
 475 (iii) any conditions that exist as a precedent to coverage; and  
 476 (iv) any exclusion from coverage for secondary medical conditions that may result  
 477 from the use of an excluded drug.  
 478 [~~(e)~~ (d) (i) The department shall develop examples of limitations or exclusions of a  
 479 secondary medical condition that an insurer may use under Subsection (2)(a)[~~(iii)~~](i)(C).  
 480 (ii) Examples of a limitation or exclusion of coverage provided under Subsection  
 481 (2)(a)[~~(iii)~~](i)(C) or otherwise are for illustrative purposes only, and the failure of a particular  
 482 fact situation to fall within the description of an example does not, by itself, support a finding  
 483 of coverage.  
 484 (3) An insurer who offers a health [care] benefit plan under Chapter 30, Individual,  
 485 Small Employer, and Group Health Insurance Act, shall[: (a) until January 1, 2010, offer the  
 486 basic health care plan described in Subsection (4) subject to the open enrollment provisions of  
 487 Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and (b) beginning  
 488 January 1, 2010,] offer a basic health care plan subject to the open enrollment provisions of  
 489 Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:  
 490 [(i) (a) is a federally qualified high deductible health plan;  
 491 [(ii) (b) has the lowest deductible that qualifies under a federally qualified high  
 492 deductible health plan, as adjusted by federal law; and

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

495            [~~(4) Until January 1, 2010, the Basic Health Care Plan under this section shall provide~~  
496 ~~for:]~~

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

498            [~~(b) an annual maximum benefit per person not less than \$250,000;]~~

499            [~~(c) an out-of-pocket maximum of cost-sharing features:]~~

500            [~~(i) including:]~~

501            [~~(A) a deductible;]~~

502            [~~(B) a copayment; and]~~

503            [~~(C) coinsurance;]~~

504            [~~(ii) not to exceed \$5,000 per person; and]~~

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

507            [~~(d) in relation to its cost-sharing features:]~~

508            [~~(i) a deductible of:]~~

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

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

512            [~~(ii) (A) a copayment of not less than:]~~

513            [~~(I) \$25 per visit for office services; and]~~

514            [~~(H) \$150 per visit to an emergency room; or]~~

515            [~~(B) coinsurance of not less than:]~~

516            [~~(I) 20% per visit for office services; and]~~

517            [~~(H) 20% per visit for an emergency room; and]~~

518            [~~(e) in relation to cost-sharing features for prescription drugs:]~~

519            [~~(i) (A) a deductible not to exceed \$1,000 per person; and]~~

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

522            [~~(ii) (A) a copayment of not less than:]~~

523            [~~(I) the lesser of the cost of the prescription drug or \$15 for the lowest level of cost for~~

524 ~~prescription drugs;]~~

525 ~~[(H) the lesser of the cost of the prescription drug or \$25 for the second level of cost for~~  
526 ~~prescription drugs; and]~~

527 ~~[(HH) the lesser of the cost of the prescription drug or \$35 for the highest level of cost~~  
528 ~~for prescription drugs; or]~~

529 ~~[(B) coinsurance of not less than:]~~

530 ~~[(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for~~  
531 ~~prescription drugs;]~~

532 ~~[(H) the lesser of the cost of the prescription drug or 40% for the second level of cost~~  
533 ~~for prescription drugs; and]~~

534 ~~[(HH) the lesser of the cost of the prescription drug or 60% for the highest level of cost~~  
535 ~~for prescription drugs;]~~

536 ~~[(5) The department shall include in its yearly insurance market report information~~  
537 ~~about:]~~

538 ~~[(a) the types of health benefit plans sold on the Internet portal created in Section~~  
539 ~~63M-1-2504;]~~

540 ~~[(b) the number of insurers participating in the defined contribution market on the~~  
541 ~~Internet portal;]~~

542 ~~[(c) the number of employers and covered lives in the defined contribution market;~~  
543 ~~and]~~

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

546 ~~[(6)] (4) The commissioner;~~

547 ~~(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to~~  
548 ~~the Health Insurance Exchange created under Subsection 63M-1-2504; and~~

549 ~~(b) may request information from an insurer to verify the information submitted by the~~  
550 ~~insurer [to the Internet portal under Subsection 63M-1-2506(4)] under this section.~~

551 ~~(5) The commissioner shall:~~

552 ~~(a) convene a group of insurers, a member representing the Public Employees' Benefit~~  
553 ~~and Insurance Program, consumers, and an organization described in Subsection~~  
554 ~~31A-22-614.6(3)(b), to develop information for consumers to compare health insurers and~~

555 health benefit plans on the Health Insurance Exchange, which shall include consideration of:

556 (i) the number and cost of an insurer's denied health claims;

557 (ii) the cost of denied claims that is transferred to providers;

558 (iii) the average out-of-pocket expenses incurred by participants in each health benefit

559 plan that is offered by an insurer in the Health Insurance Exchange;

560 (iv) the relative efficiency and quality of claims administration and other administrative

561 processes for each insurer offering plans in the Health Insurance Exchange; and

562 (v) consumer assessment of each insurer or health benefit plan;

563 (b) adopt an administrative rule that establishes:

564 (i) definition of terms;

565 (ii) the methodology for determining and comparing the insurer transparency

566 information;

567 (iii) the data, and format of the data that an insurer must submit to the department in

568 order to facilitate the consumer comparison on the Health Insurance Exchange in accordance

569 with Section 63M-1-2506; and

570 (iv) the dates on which the insurer must submit the data to the department in order for

571 the department to transmit the data to the Health Insurance Exchange in accordance with

572 Section 63M-1-2506; and

573 (c) implement the rules adopted under Subsection (5)(b) in a manner that protects the

574 business confidentiality of the insurer.

575 Section 8. Section **31A-22-614.6** is amended to read:

576 **31A-22-614.6. Health care delivery and payment reform demonstration projects.**

577 (1) The Legislature finds that:

578 (a) current health care delivery and payment systems do not provide systemwide

579 aligned incentives for the appropriate delivery of health care;

580 (b) some health care providers and health care payers have developed ideas for health

581 care delivery and payment system reform, but lack the critical number of patient lives and

582 payer involvement to accomplish systemwide reform; and

583 (c) there is a compelling state interest to encourage as many health care providers and

584 health care payers to join together and coordinate efforts at systemwide health care delivery and

585 payment reform.

586 (2) (a) The Office of Consumer Health Services within the Governor's Office of  
587 Economic Development shall convene meetings of health care providers and health care payers  
588 through a neutral, non-biased entity that can demonstrate it has the support of a broad base of  
589 the participants in this process for the purpose of coordinating broad based demonstration  
590 projects for health care delivery and payment reform.

591 (b) (i) The speaker of the House of Representatives may appoint a person who is a  
592 member of the House of Representatives, or from the Office of Legislative Research and  
593 General Counsel, to attend the meetings convened under Subsection (2)(a).

594 (ii) The president of the Senate may appoint a person who is a senator, or from the  
595 Office of Legislative Research and General Counsel, to attend the meetings convened under  
596 Subsection (2)(a).

597 (c) Participation in the coordination efforts by health care providers and health care  
598 payers is voluntary, but is encouraged.

599 (3) The commissioner and the Office of Consumer Health Services shall facilitate  
600 several coordinated broad based demonstration projects for health care delivery reform and  
601 health care payment reform between [~~various~~] one or more health care providers and one or  
602 more health care payers who elect to participate in the demonstration projects by:

603 (a) consulting with health care providers and health care payers who elect to join  
604 together in a broad based reform demonstration project; [~~and~~]

605 (b) consulting with a neutral, non-biased third party with an established record for  
606 broad based, multi-payer and multi-provider quality assurance efforts and data collection;

607 (c) applying for grants and assistance that may be available for creating and  
608 implementing the demonstration projects; and

609 [~~(b)~~] (d) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah  
610 Administrative Rulemaking Act, as necessary to develop, oversee, and implement the  
611 demonstration [~~project~~] projects.

612 (4) The Office of Consumer Health Services and the commissioner shall report to the  
613 Health System Reform Task Force by October [~~2009~~] 2010, and to the Legislature's Business  
614 and Labor Interim Committee every October thereafter regarding the progress towards  
615 coordination of broad based health care system payment and delivery reform.

616 Section 9. Section ~~31A-22-618.5~~ is amended to read:

617 **31A-22-618.5. Health plan offerings.**

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

620 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance  
621 Organizations and Limited Health Plans:

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

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

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

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

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

629 (6);

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

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

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

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

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

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

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

- 648 (i) tier one contracted providers;
- 649 (ii) tier two contracted providers who the insurer must reimburse at least 75% of tier  
650 one providers; and
- 651 (iii) one or more tiers of non-contracted providers; and
- 652 (b) notwithstanding Subsection 31A-22-617(9) may offer a health benefit plan that is  
653 not subject to [~~Subsection 31A-22-617(9)~~ and] Section 31A-22-618;
- 654 (c) beginning July 1, 2012, may offer products under Subsection (3)(a) that:
- 655 (i) are not subject to Subsection 31A-22-617(2); and
- 656 (ii) are subject to the reimbursement requirements in Section 31A-8-501;
- 657 (d) when offering a health plan under this Subsection (3), shall provide coverage of  
658 emergency care services as required by Section 31A-22-627 by providing coverage at a  
659 reimbursement level of at least 75% of tier one providers; and
- 660 (e) are not subject to coverage mandates enacted after January 1, 2009 that are not  
661 required by federal law, provided that an insurer offers one plan that covers a mandate enacted  
662 after January 1, 2009.
- 663 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under  
664 Subsection (2)(b).
- 665 (5) (a) Any difference in price between a health benefit plan offered under Subsections  
666 (2)(a) and (b) shall be based on actuarially sound data.
- 667 (b) Any difference in price between a health benefit plan offered under Subsections  
668 (3)(a) and (b) shall be based on actuarially sound data.
- 669 (6) Nothing in this section limits the number of health benefit plans that an insurer may  
670 offer.

671 Section 10. Section **31A-22-625** is amended to read:

672 **31A-22-625. Catastrophic coverage of mental health conditions.**

673 (1) As used in this section:

- 674 (a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan  
675 or health maintenance organization contract that does not impose a lifetime limit, annual  
676 payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket  
677 limit that places a greater financial burden on an insured for the evaluation and treatment of a  
678 mental health condition than for the evaluation and treatment of a physical health condition.

679 (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing  
680 factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum  
681 out-of-pocket limit.

682 (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket  
683 limit for physical health conditions and another maximum out-of-pocket limit for mental health  
684 conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket  
685 limit for mental health conditions may not exceed the out-of-pocket limit for physical health  
686 conditions.

687 (b) (i) "50/50 mental health coverage" means coverage in a health benefit plan or health  
688 maintenance organization contract that pays for at least 50% of covered services for the  
689 diagnosis and treatment of mental health conditions.

690 (ii) "50/50 mental health coverage" may include a restriction on episodic limits,  
691 inpatient or outpatient service limits, or maximum out-of-pocket limits.

692 (c) "Large employer" is as defined in Section 31A-1-301.

693 (d) (i) "Mental health condition" means any condition or disorder involving mental  
694 illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical  
695 Manual, as periodically revised.

696 (ii) "Mental health condition" does not include the following when diagnosed as the  
697 primary or substantial reason or need for treatment:

- 698 (A) marital or family problem;
- 699 (B) social, occupational, religious, or other social maladjustment;
- 700 (C) conduct disorder;
- 701 (D) chronic adjustment disorder;
- 702 (E) psychosexual disorder;
- 703 (F) chronic organic brain syndrome;
- 704 (G) personality disorder;
- 705 (H) specific developmental disorder or learning disability; or
- 706 (I) mental retardation.

707 (e) "Small employer" is as defined in Section 31A-1-301.

708 (2) (a) At the time of purchase and renewal, an insurer shall offer to each small  
709 employer that it insures or seeks to insure a choice between catastrophic mental health

710 coverage and 50/50 mental health coverage.

711 (b) In addition to Subsection (2)(a), an insurer may offer to provide:

712 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels  
713 that exceed the minimum requirements of this section; or

714 (ii) coverage that excludes benefits for mental health conditions.

715 (c) A small employer may, at its option, choose either catastrophic mental health  
716 coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b),  
717 regardless of the employer's previous coverage for mental health conditions.

718 (d) An insurer is exempt from the 30% index rating restriction in [~~Subsection~~  
719 ~~31A-30-106(1)(b)~~] Section 31A-30-106.1 and, for the first year only that catastrophic mental  
720 health coverage is chosen, the 15% annual adjustment restriction in [~~Subsection~~  
721 ~~31A-30-106(1)(c)(ii)~~] Section 31A-30-106.1, for any small employer with 20 or less enrolled  
722 employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

723 (3) (a) At the time of purchase and renewal of a health benefit plan, an insurer shall  
724 offer catastrophic mental health coverage to each large employer that it insures or seeks to  
725 insure.

726 (b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental  
727 health coverage at levels that exceed the minimum requirements of this section.

728 (c) A large employer may, at its option, choose either catastrophic mental health  
729 coverage, coverage that excludes benefits for mental health conditions, or coverage offered  
730 under Subsection (3)(b).

731 (4) (a) An insurer may provide catastrophic mental health coverage through a managed  
732 care organization or system in a manner consistent with the provisions in Chapter 8, Health  
733 Maintenance Organizations and Limited Health Plans, regardless of whether the policy or  
734 contract uses a managed care organization or system for the treatment of physical health  
735 conditions.

736 (b) (i) Notwithstanding any other provision of this title, an insurer may:

737 (A) establish a closed panel of providers for catastrophic mental health coverage; and

738 (B) refuse to provide any benefit to be paid for services rendered by a nonpanel  
739 provider unless:

740 (I) the insured is referred to a nonpanel provider with the prior authorization of the

741 insurer; and

742 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment  
743 guidelines.

744 (ii) If an insured receives services from a nonpanel provider in the manner permitted by  
745 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the  
746 average amount paid by the insurer for comparable services of panel providers under a  
747 noncapitated arrangement who are members of the same class of health care providers.

748 (iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to  
749 authorize a referral to a nonpanel provider.

750 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a  
751 mental health condition must be rendered:

752 (i) by a mental health therapist as defined in Section 58-60-102; or

753 (ii) in a health care facility licensed or otherwise authorized to provide mental health  
754 services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or  
755 Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the  
756 treatment of a mental health condition pursuant to a written plan.

757 (5) The commissioner may prohibit a policy or contract that provides mental health  
758 coverage in a manner that is inconsistent with this section.

759 (6) The commissioner shall:

760 (a) adopt rules as necessary to ensure compliance with this section; and

761 (b) provide general figures on the percentage of contracts and policies that include no  
762 mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage,  
763 and coverage that exceeds the minimum requirements of this section.

764 (7) The Health and Human Services Interim Committee shall review:

765 (a) the impact of this section on insurers, employers, providers, and consumers of  
766 mental health services before January 1, 2004; and

767 (b) make a recommendation as to whether the provisions of this section should be  
768 modified and whether the cost-sharing requirements for mental health conditions should be the  
769 same as for physical health conditions.

770 (8) (a) An insurer shall offer catastrophic mental health coverage as part of a health  
771 maintenance organization contract that is governed by Chapter 8, Health Maintenance

772 Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.

773 (b) An insurer shall offer catastrophic mental health coverage as a part of a health  
774 benefit plan that is not governed by Chapter 8, Health Maintenance Organizations and Limited  
775 Health Plans, that is in effect on or after July 1, 2001.

776 (c) This section does not apply to the purchase or renewal of an individual insurance  
777 policy or contract.

778 (d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as  
779 discouraging or otherwise preventing insurers from continuing to provide mental health  
780 coverage in connection with an individual policy or contract.

781 (9) This section shall be repealed in accordance with Section 63I-1-231.

782 Section 11. Section **31A-22-635** is amended to read:

783 **31A-22-635. Development of uniform health insurance application.**

784 (1) For purposes of this section, "insurer":

785 (a) is defined in Subsection 31A-22-634(1); and

786 (b) includes the state employee's risk pool under Section 49-20-202.

787 (2) (a) [~~Beginning July 1, 2009, all insurers~~] Insurers offering [health insurance] a  
788 health benefit plan to an individual or small employer shall:

789 (i) except as provided in Subsection (6), use a uniform application form[-], which,  
790 beginning October 1, 2010:

791 (A) except for cancer and transplants, may not include questions about an applicant's  
792 health history prior to the previous 10 years; and

793 (B) shall be shortened and simplified in accordance with rules adopted by the  
794 department; and

795 (ii) use a uniform waiver of coverage form, which:

796 (A) may not include health status related questions other than pregnancy; and

797 (B) is limited to:

798 (I) information that identifies the employee;

799 (II) proof of the employee's insurance coverage; and

800 (III) a statement that the employee declines coverage with a particular employer group.

801 (b) Notwithstanding the requirements of Subsection (2)(a), the uniform application and  
802 uniform waiver of coverage forms may be combined or modified to facilitate:

803 (i) the electronic submission and processing of an application through the Health  
804 Insurance Exchange created pursuant to Section 63M-1-2504 or directly to all carriers; and

805 (ii) a more efficient and understandable experience for a consumer submitting an  
806 application in the Health Insurance Exchange or directly to all carriers.

807 (3) An insurer offering a defined contribution arrangement health benefit plan in the  
808 Health Insurance Exchange to a large group shall use a large group uniform application, and  
809 uniform waiver of coverage form that is adopted by the department by administrative rule.

810 ~~[(3)]~~ (4) (a) (i) The uniform application form, and uniform waiver form, shall be  
811 adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah  
812 Administrative Rulemaking Act.

813 (ii) Modifications to the uniform application necessary to facilitate the electronic  
814 submission and processing of an application through the Health Insurance Exchange shall be  
815 adopted by administrative rule adopted by the Office of Consumer Health Services in  
816 accordance with Section 63M-1-2506.

817 (b) The commissioner shall ~~consult with~~ convene the health insurance industry ~~[when~~  
818 adopting the uniform application form], the Office of Consumer Health Services, and  
819 consumers to review the uniform application for the individual and small group market, and the  
820 large group market, and make recommendations regarding the uniform applications. The  
821 department shall report the findings of the group convened pursuant to this Subsection (4)(b) to  
822 the Legislature no later than July 1, 2010.

823 ~~[(4)]~~ (5) (a) Beginning ~~[July 1, 2010, all insurers]~~ October 1, 2010, an insurer who  
824 offers a health benefit plan on the Health Insurance Exchange created in Section 63M-1-2504,  
825 shall ~~[offer compatible systems of electronic submission of application forms, approved by the~~  
826 commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.  
827 The systems approved by the commissioner may include monitoring and disseminating  
828 information concerning eligibility and coverage of individuals.];

829 (i) accept and process an electronic submission of the uniform application or uniform  
830 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to  
831 Section 63M-1-2506; and

832 (ii) if requested, provide the applicant with a copy of the completed application either  
833 by mail or electronically.

834 (b) The commissioner shall regulate any fees charged by insurers to an enrollee for a  
835 uniform application form or electronic submission of the application forms.

836 (6) An insurer offering a health benefit plan outside the Health Insurance Exchange  
837 may use the uniform application in effect prior to May 15, 2010, until January 1, 2011.

838 Section 12. Section **31A-22-723** is amended to read:

839 **31A-22-723. Group and blanket conversion coverage.**

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

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

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

849 (b) has exhausted either:

850 (i) Utah mini-COBRA coverage as required in Section 31A-22-722;

851 (ii) federal COBRA coverage; or

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

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

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

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

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

858 (i) catastrophic benefits;

859 (ii) aggregate stop loss benefits;

860 (iii) specific stop loss benefits;

861 (iv) benefits for specific diseases;

862 (v) accidental injuries only;

863 (vi) dental; or

864 (vii) vision;

865 (b) is an income replacement policy;  
866 (c) was terminated because the insured:  
867 (i) failed to pay any required individual contribution;  
868 (ii) performed an act or practice that constitutes fraud in connection with the coverage;  
869 or  
870 (iii) made intentional misrepresentation of material fact under the terms of coverage; or  
871 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or  
872 31A-30-107(2)(a).  
873 (4) (a) The employer shall provide written notification of the right to an individual  
874 conversion policy within 30 days of the insured's termination of coverage to:  
875 (i) the terminated insured;  
876 (ii) the ex-spouse; or  
877 (iii) in the case of the death of the insured:  
878 (A) the surviving spouse; and  
879 (B) the guardian of any dependents, if different from a surviving spouse.  
880 (b) The notification required by Subsection (4)(a) shall:  
881 (i) be sent by first class mail;  
882 (ii) contain the name, address, and telephone number of the insurer that will provide  
883 the conversion coverage; and  
884 (iii) be sent to the insured's last-known address as shown on the records of the  
885 employer of:  
886 (A) the insured;  
887 (B) the ex-spouse; and  
888 (C) if the policy terminates by reason of the death of the insured to:  
889 (I) the surviving spouse; and  
890 (II) the guardian of any dependents, if different from a surviving spouse.  
891 (5) (a) An insurer is not required to issue a converted policy which provides benefits in  
892 excess of those provided under the group policy from which conversion is made.  
893 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health  
894 benefit plan, the employee or member shall be offered:  
895 (i) at least the basic benefit plan as provided in Section 31A-22-613.5 through

896 December 31, 2009; and

897 (ii) beginning January 1, 2010, only the alternative coverage as provided in Subsection  
898 31A-22-724(1)(a).

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

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

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

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

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

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

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

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

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

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

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

- 927 (i) the insured;
- 928 (ii) a spouse of the insured; or
- 929 (iii) a dependent of the insured.

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

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

- 935 (a) a dependent is no longer eligible under the policy;
- 936 (b) for a network plan, if the individual no longer lives, resides, or works in:
  - 937 (i) the insured's service area; or
  - 938 (ii) the area for which the covered carrier is authorized to do business;
- 939 (c) the individual fails to pay premiums or contributions in accordance with the terms  
940 of the converted policy, including any timeliness requirements;
- 941 (d) the individual performs an act or practice that constitutes fraud in connection with  
942 the coverage;
- 943 (e) the individual makes an intentional misrepresentation of material fact under the  
944 terms of the coverage; or
- 945 (f) coverage is terminated uniformly without regard to any health status-related factor  
946 relating to any covered individual.

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

949 (14) An insurer is only required to offer a conversion policy that complies with  
950 Subsection 31A-22-724(1)(b) and, notwithstanding Sections 31A-8-402.5 and 31A-30-107.1,  
951 may discontinue any other conversion policy if:

- 952 (a) the discontinued conversion policy is discontinued uniformly without regard to any  
953 health related factor;
- 954 (b) any affected individual is provided with 90 days advanced written notice of the  
955 discontinuation of the existing conversion policy;
- 956 (c) the policy holder is offered the insurer's conversion policy that complies with  
957 Subsection 31A-22-724(1)(b); and

958 (d) the policy holder is not re-rated for purposes of premium calculation.

959 Section 13. Section **31A-30-103** is amended to read:

960 **31A-30-103. Definitions.**

961 As used in this chapter:

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

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

970 (3) "Base premium rate" means, for each class of business as to a rating period, the  
971 lowest premium rate charged or that could have been charged under a rating system ~~H~~→ [f] **for that**  
972 **class of business** [f] ←~~H~~ by the covered carrier to covered insureds with similar case  
972a characteristics  
973 for health benefit plans with the same or similar coverage.

974 (4) "Basic benefit plan" or "basic coverage" means the coverage provided in the Basic  
975 Health Care Plan under Section 31A-22-613.5.

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

978 (a) an insurance company;

979 (b) a prepaid hospital or medical care plan;

980 (c) a health maintenance organization;

981 (d) a multiple employer welfare arrangement; and

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

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

986 (b) "Case characteristics" do not include:

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

988 (ii) claim experience; and

989 (iii) health status.

990 (7) "Class of business" means all or a separate grouping of covered insureds  
991 ~~[established under]~~ that is permitted by the department in accordance with Section  
992 31A-30-105.

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

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

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

999 (11) "Covered insureds" means small employers and individuals who are issued a  
1000 health benefit plan that is subject to this chapter.

1001 (12) "Dependent" means an individual to the extent that the individual is defined to be  
1002 a dependent by:

1003 (a) the health benefit plan covering the covered individual; and

1004 (b) Chapter 22, Part 6, Accident and Health Insurance.

1005 (13) "Established geographic service area" means a geographical area approved by the  
1006 commissioner within which the carrier is authorized to provide coverage.

1007 (14) "Index rate" means, for each class of business as to a rating period for covered  
1008 insureds with similar case characteristics, the arithmetic average of the applicable base  
1009 premium rate and the corresponding highest premium rate.

1010 (15) "Individual carrier" means a carrier that provides coverage on an individual basis  
1011 through a health benefit plan regardless of whether:

1012 (a) coverage is offered through:

1013 (i) an association;

1014 (ii) a trust;

1015 (iii) a discretionary group; or

1016 (iv) other similar groups; or

1017 (b) the policy or contract is situated out-of-state.

1018 (16) "Individual conversion policy" means a conversion policy issued to:

1019 (a) an individual; or

1020 (b) an individual with a family.

1021 (17) "Individual coverage count" means the number of natural persons covered under a  
1022 carrier's health benefit products that are individual policies.

1023 (18) "Individual enrollment cap" means the percentage set by the commissioner in  
1024 accordance with Section 31A-30-110.

1025 (19) "New business premium rate" means, for each class of business as to a rating  
1026 period, the lowest premium rate charged or offered, or that could have been charged or offered,  
1027 by the carrier to covered insureds with similar case characteristics for newly issued health  
1028 benefit plans with the same or similar coverage.

1029 ~~[(20) "Plan year" means the year that is designated as the plan year in the plan  
1030 document of a group health plan, except that if the plan document does not designate a plan  
1031 year or if there is not a plan document, the plan year is:]~~

1032 ~~[(a) the deductible or limit year used under the plan;]~~

1033 ~~[(b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;]~~

1034 ~~[(c) if the plan does not impose a deductible or limit on a yearly basis and either the  
1035 plan is not insured or the insurance policy is not renewed on an annual basis, the employer's  
1036 taxable year; or]~~

1037 ~~[(d) in any case not described in Subsections (20)(a) through (c), the calendar year.]~~

1038 ~~[(21) "Preexisting condition" is as defined in Section 31A-1-301.]~~

1039 ~~[(22)]~~ (20) "Premium" means all monies paid by covered insureds and covered  
1040 individuals as a condition of receiving coverage from a covered carrier, including any fees or  
1041 other contributions associated with the health benefit plan.

1042 ~~[(23)]~~ (21) (a) "Rating period" means the calendar period for which premium rates  
1043 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1044 (b) A covered carrier may not have:

1045 (i) more than one rating period in any calendar month; and

1046 (ii) no more than 12 rating periods in any calendar year.

1047 ~~[(24)]~~ (22) "Resident" means an individual who has resided in this state for at least 12  
1048 consecutive months immediately preceding the date of application.

1049 ~~[(25)]~~ (23) "Short-term limited duration insurance" means a health benefit product that:

1050 (a) is not renewable; and

1051 (b) has an expiration date specified in the contract that is less than 364 days after the  
1052 date the plan became effective.

1053 [(26)] (24) "Small employer carrier" means a carrier that provides health benefit plans  
1054 covering eligible employees of one or more small employers in this state, regardless of  
1055 whether:

1056 (a) coverage is offered through:

1057 (i) an association;

1058 (ii) a trust;

1059 (iii) a discretionary group; or

1060 (iv) other similar grouping; or

1061 (b) the policy or contract is situated out-of-state.

1062 [(27)] (25) "Uninsurable" means an individual who:

1063 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the  
1064 underwriting criteria established in Subsection 31A-29-111(5); or

1065 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

1066 (ii) has a condition of health that does not meet consistently applied underwriting  
1067 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)  
1068 and (j) for which coverage the applicant is applying.

1069 [(28)] (26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for  
1070 purposes of this formula:

1071 (a) "CI" means the carrier's individual coverage count as of December 31 of the  
1072 preceding year; and

1073 (b) "UC" means the number of uninsurable individuals who were issued an individual  
1074 policy on or after July 1, 1997.

1075 Section 14. Section **31A-30-105** is amended to read:

1076 **31A-30-105. Establishment of classes of business.**

1077 (1) [A] For policies that go into effect on or after January 1, 2011, a covered carrier  
1078 may not establish a separate class of business [only to reflect] unless:

1079 (a) the covered carrier submits an application to the department to establish a separate  
1080 class of business;

1081 (b) the covered carrier demonstrates to the satisfaction of the department that a separate

1082 class of business is justified under the provisions of this section; and

1083 (c) the department approves the carrier's application for the use of a separate class of  
1084 business.

1085 (2) (a) The presumption of the department shall be against the use of a separate class of  
1086 business by a covered insured, except when the covered carrier demonstrates that the  
1087 provisions of this Subsection (2) apply.

1088 (b) The department may approve the use of a separate class of business only if the  
1089 covered carrier can demonstrate that the use of a separate class of business is necessary due to  
1090 substantial differences in either expected claims experience or administrative costs related to  
1091 the following reasons:

1092 ~~[(a)]~~ (i) the covered carrier uses more than one type of system for the marketing and  
1093 sale of health benefit plans to covered insureds;

1094 ~~[(b)]~~ (ii) the covered carrier has acquired a class of business from another covered  
1095 carrier; or

1096 ~~[(c)]~~ (iii) the covered carrier provides coverage to one or more association groups.

1097 ~~[(2) A covered carrier may establish up to nine separate classes of business under~~  
1098 ~~Subsection (1).]~~

1099 (3) The commissioner may establish regulations to provide for a period of transition in  
1100 order for a covered carrier to come into compliance with Subsection (2) in the instance of  
1101 acquisition of an additional class of business from another covered carrier.

1102 (4) The commissioner may approve the establishment of ~~[additional]~~ up to five classes  
1103 of business per covered carrier upon application to the commissioner and a finding by the  
1104 commissioner that such action would substantially enhance the efficiency and fairness of the  
1105 health insurance marketplace subject to this chapter.

1106 (5) A covered carrier may not establish a class of business based solely on the  
1107 marketing or sale of a health benefit plan as a defined contribution arrangement health benefit  
1108 plan, or through the Health Insurance Exchange.

1109 Section 15. Section **31A-30-106** is amended to read:

1110 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

1111 (1) Premium rates for health benefit plans for individuals under this chapter are subject  
1112 to the provisions of this ~~[Subsection (1)]~~ section.

1113 (a) The index rate for a rating period for any class of business may not exceed the  
1114 index rate for any other class of business by more than 20%.

1115 (b) (i) For a class of business, the premium rates charged during a rating period to  
1116 covered insureds with similar case characteristics for the same or similar coverage, or the rates  
1117 that could be charged to ~~[such employers]~~ the individual under the rating system for that class  
1118 of business, may not vary from the index rate by more than 30% of the index rate~~[-except as~~  
1119 ~~provided in Section 31A-22-625]~~ provided in Section 31A-30-106.1.

1120 (ii) A ~~[covered]~~ carrier that offers individual and small employer health benefit plans  
1121 may use the small employer index rates to establish the rate limitations for individual policies,  
1122 even if some individual policies are rated below the small employer base rate.

1123 (c) The percentage increase in the premium rate charged to a covered insured for a new  
1124 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
1125 the following:

1126 (i) the percentage change in the new business premium rate measured from the first day  
1127 of the prior rating period to the first day of the new rating period;

1128 (ii) any adjustment, not to exceed 15% annually ~~[and adjusted pro rata]~~ for rating  
1129 periods of less than one year, due to the claim experience, health status, or duration of coverage  
1130 of the covered individuals as determined from the ~~[covered carrier's]~~ rate manual for the class  
1131 of business~~[-except as provided in Section 31A-22-625]~~ of the carrier offering an individual  
1132 health benefit plan; and

1133 (iii) any adjustment due to change in coverage or change in the case characteristics of  
1134 the covered insured as determined from the ~~[covered carrier's]~~ rate manual for the class of  
1135 business of the carrier offering an individual health benefit plan.

1136 ~~[(d) (i) Adjustments in rates for claims experience, health status, and duration from~~  
1137 ~~issue may not be charged to individual employees or dependents.]~~

1138 ~~[(ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the~~  
1139 ~~rates charged for all employees and dependents of the small employer.]~~

1140 ~~[(e) A covered carrier may use industry as a case characteristic in establishing premium~~  
1141 ~~rates, provided that the highest rate factor associated with any industry classification does not~~  
1142 ~~exceed the lowest rate factor associated with any industry classification by more than 15%.]~~

1143 ~~[(f) (i) Covered carriers]~~

1144 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,  
 1145 including case characteristics, consistently with respect to all covered insureds in a class of  
 1146 business.

1147 (ii) Rating factors shall produce premiums for identical ~~[groups]~~ individuals that:  
 1148 (A) differ only by the amounts attributable to plan design; and  
 1149 (B) do not reflect differences due to the nature of the ~~[groups]~~ individuals assumed to  
 1150 select particular health benefit products.

1151 (iii) A ~~[covered]~~ carrier offering an individual health benefit plan shall treat all health  
 1152 benefit plans issued or renewed in the same calendar month as having the same rating period.

1153 ~~[(g)]~~ (e) For the purposes of this Subsection (1), a health benefit plan that uses a  
 1154 restricted network provision may not be considered similar coverage to a health benefit plan  
 1155 that does not use a restricted network provision, provided that use of the restricted network  
 1156 provision results in substantial difference in claims costs.

1157 ~~[(h) The covered carrier]~~ (f) A carrier offering a health benefit plan to an individual  
 1158 may not, without prior approval of the commissioner, use case characteristics other than:

1159 (i) age;

1160 ~~H~~→ [f] (ii) gender; [h] ←~~H~~

1161 ~~[(iii) industry;]~~

1162 ~~[(iv)]~~ ~~H~~→ [(ii)] (iii) ←~~H~~ geographic area; and

1163 ~~[(v)]~~ ~~H~~→ [(iii)] (iv) ←~~H~~ family composition~~[-and]~~.

1164 ~~[(vi) group size.]~~

1165 ~~[(f)]~~ (g) (i) The commissioner shall establish rules in accordance with Title 63G,  
 1166 Chapter 3, Utah Administrative Rulemaking Act, to:

1167 (A) implement this chapter; and

1168 (B) assure that rating practices used by ~~[covered]~~ carriers who offer health benefit  
 1169 plans to individuals are consistent with the purposes of this chapter.

1170 (ii) The rules described in Subsection (1)~~[(f)]~~(g)(i) may include rules that:

1171 (A) assure that differences in rates charged for health benefit products by ~~[covered]~~  
 1172 carriers who offer health benefit plans to individuals are reasonable and reflect objective  
 1173 differences in plan design, not including differences due to the nature of the ~~[groups]~~  
 1174 individuals assumed to select particular health benefit products;

1175 (B) prescribe the manner in which case characteristics may be used by ~~covered~~  
1176 carriers who offer health benefit plans to individuals;

1177 (C) implement the individual enrollment cap under Section 31A-30-110, including  
1178 specifying:

1179 (I) the contents for certification;

1180 (II) auditing standards;

1181 (III) underwriting criteria for uninsurable classification; and

1182 (IV) limitations on high risk enrollees under Section 31A-30-111; and

1183 (D) establish the individual enrollment cap under Subsection 31A-30-110(1).

1184 ~~[(j)]~~ (h) Before implementing regulations for underwriting criteria for uninsurable  
1185 classification, the commissioner shall contract with an independent consulting organization to  
1186 develop industry-wide underwriting criteria for uninsurability based on an individual's expected  
1187 claims under open enrollment coverage exceeding 325% of that expected for a standard  
1188 insurable individual with the same case characteristics.

1189 ~~[(k)]~~ (i) The commissioner shall revise rules issued for Sections 31A-22-602 and  
1190 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance  
1191 with this section.

1192 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit  
1193 product into which the covered carrier is no longer enrolling new covered insureds, the covered  
1194 carrier shall use the percentage change in the base premium rate, provided that the change does  
1195 not exceed, on a percentage basis, the change in the new business premium rate for the most  
1196 similar health benefit product into which the covered carrier is actively enrolling new covered  
1197 insureds.

1198 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of  
1199 a class of business.

1200 (b) A covered carrier may not offer to transfer a covered insured into or out of a class  
1201 of business unless the offer is made to transfer all covered insureds in the class of business  
1202 without regard to:

1203 (i) ~~[to]~~ case characteristics;

1204 (ii) claim experience;

1205 (iii) health status; or

1206 (iv) duration of coverage since issue.

1207 [~~(4)(a) Each covered carrier~~]

1208 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the  
1209 [~~covered~~] carrier's principal place of business a complete and detailed description of its rating  
1210 practices and renewal underwriting practices, including information and documentation that  
1211 demonstrate that the [~~covered~~] carrier's rating methods and practices are:

1212 (i) based upon commonly accepted actuarial assumptions; and

1213 (ii) in accordance with sound actuarial principles.

1214 (b) (i) Each [~~covered~~] carrier subject to this section shall file with the commissioner,  
1215 on or before April 1 of each year, in a form, manner, and containing such information as  
1216 prescribed by the commissioner, an actuarial certification certifying that:

1217 (A) the [~~covered~~] carrier is in compliance with this chapter; and

1218 (B) the rating methods of the [~~covered~~] carrier are actuarially sound.

1219 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the  
1220 [~~covered~~] carrier at the [~~covered~~] carrier's principal place of business.

1221 (c) A [~~covered~~] carrier shall make the information and documentation described in this  
1222 Subsection (4) available to the commissioner upon request.

1223 (d) Records submitted to the commissioner under this section shall be maintained by  
1224 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
1225 Access and Management Act.

1226 Section 16. Section **31A-30-106.1** is enacted to read:

1227 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

1228 (1) Premium rates for small employer health benefit plans under this chapter are  
1229 subject to the provisions of this section for a health benefit plan that is issued or renewed, on or  
1230 after January 1, 2011.

1231 (2) (a) The index rate for a rating period for any class of business may not exceed the  
1232 index rate for any other class of business by more than 20%.

1233 (b) For a class of business, the premium rates charged during a rating period to covered  
1234 insureds with similar case characteristics for the same or similar coverage, or the rates that  
1235 could be charged to an employer group under the rating system for that class of business, may  
1236 not vary from the index rate by more than 30% of the index rate, except when catastrophic

1237 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

1238 (3) The percentage increase in the premium rate charged to a covered insured for a new  
1239 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
1240 the following:

1241 (a) the percentage change in the new business premium rate measured from the first  
1242 day of the prior rating period to the first day of the new rating period;

1243 (b) any adjustment, not to exceed 15% annually for rating periods of less than one year,  
1244 due to the claim experience, health status, or duration of coverage of the covered individuals as  
1245 determined from the small employer carrier's rate manual for the class of business, except when  
1246 catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d);  
1247 and

1248 (c) any adjustment due to change in coverage or change in the case characteristics of  
1249 the covered insured as determined for the class of business from the small employer carrier's  
1250 rate manual.

1251 (4) (a) Adjustments in rates for claims experience, health status, and duration from  
1252 issue may not be charged to individual employees or dependents.

1253 (b) Rating adjustments and factors, including case characteristics, shall be applied  
1254 uniformly and consistently to the rates charged for all employees and dependents of the small  
1255 employer.

1256 (c) Rating factors shall produce premiums for identical groups that:

1257 (i) differ only by the amounts attributable to plan design; and

1258 (ii) do not reflect differences due to the nature of the groups assumed to select  
1259 particular health benefit products.

1260 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the  
1261 same calendar month as having the same rating period.

1262 (5) A health benefit plan that uses a restricted network provision may not be considered  
1263 similar coverage to a health benefit plan that does not use a restricted network provision,  
1264 provided that use of the restricted network provision results in substantial difference in claims  
1265 costs.

1266 (6) The small employer carrier may not use case characteristics other than the  
1267 following:

- 1268 (a) age, as determined at the beginning of the plan year, limited to:
- 1269 (i) the following age bands:
- 1270 (A) less than 20;
- 1271 (B) 20-24;
- 1272 (C) 25-29;
- 1273 (D) 30-34;
- 1274 (E) 35-39;
- 1275 (F) 40-44;
- 1276 (G) 45-49;
- 1277 (H) 50-54;
- 1278 (I) 55-59;
- 1279 (J) 60-64; and
- 1280 (K) 65 and above; and
- 1281 (ii) a standard slope ratio range for each age band, applied to each family composition
- 1282 tier rating structure under Subsection (6)(c):
- 1283 (A) as developed by the department by administrative rule;
- 1284 (B) not to exceed an overall ratio of ~~H~~→ [4:1] 5:1 ←~~H~~ ; and
- 1285 (C) the age slope ratios for each age band may not overlap;
- 1286 (b) geographic area; and
- 1287 (c) family composition, limited to:
- 1288 (i) an overall ratio of ~~H~~→ [4:1] 5:1 ←~~H~~ or less; and
- 1289 (ii) a four tier rating structure that includes:
- 1290 (A) employee only;
- 1291 (B) employee plus spouse;
- 1292 (C) employee plus a dependent or dependents; and
- 1293 (D) a family, consisting of an employee plus spouse, and a dependent or dependents.
- 1294 (7) If a health benefit plan is a health benefit plan into which the small employer carrier
- 1295 is no longer enrolling new covered insureds, the small employer carrier shall use the percentage
- 1296 change in the base premium rate, provided that the change does not exceed, on a percentage
- 1297 basis, the change in the new business premium rate for the most similar health benefit product
- 1298 into which the small employer carrier is actively enrolling new covered insureds.

1299 (8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of  
1300 a class of business.

1301 (b) A covered carrier may not offer to transfer a covered insured into or out of a class  
1302 of business unless the offer is made to transfer all covered insureds in the class of business  
1303 without regard to:

1304 (i) case characteristics;

1305 (ii) claim experience;

1306 (iii) health status; or

1307 (iv) duration of coverage since issue.

1308 (9) (a) Each small employer carrier shall maintain at the small employer carrier's  
1309 principal place of business a complete and detailed description of its rating practices and  
1310 renewal underwriting practices, including information and documentation that demonstrate that  
1311 the small employer carrier's rating methods and practices are:

1312 (i) based upon commonly accepted actuarial assumptions; and

1313 (ii) in accordance with sound actuarial principles.

1314 (b) (i) Each small employer carrier shall file with the commissioner on or before April  
1315 1 of each year, in a form and manner and containing information as prescribed by the  
1316 commissioner, an actuarial certification certifying that:

1317 (A) the small employer carrier is in compliance with this chapter; and

1318 (B) the rating methods of the small employer carrier are actuarially sound.

1319 (ii) A copy of the certification required by Subsection (9)(b)(i) shall be retained by the  
1320 small employer carrier at the small employer carrier's principal place of business.

1321 (c) A small employer carrier shall make the information and documentation described  
1322 in this Subsection (9) available to the commissioner upon request.

1323 (10) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with  
1324 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

1325 (i) implement this chapter; and

1326 (ii) assure that rating practices used by small employer carriers under this section and  
1327 carriers for individual plans under Section 31A-30-106, as effective on January 1, 2011, are  
1328 consistent with the purposes of this chapter.

1329 (b) The rules may:

1330 (i) assure that differences in rates charged for health benefit plans by carriers are  
 1331 reasonable and reflect objective differences in plan design, not including differences due to the  
 1332 nature of the groups or individuals assumed to select particular health benefit plans; and

1333 (ii) prescribe the manner in which case characteristics may be used by small employer  
 1334 and individual carriers.

1335 (11) Records submitted to the commissioner under this section shall be maintained by  
 1336 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
 1337 Access and Management Act.

1338 Section 17. Section **31A-30-106.5** is amended to read:

1339 **31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.**

1340 (1) All provisions of Section [~~31A-30-106, except Subsection 31A-30-106(1)(b);~~]  
 1341 31A-30-106.1 apply to conversion policies.

1342 (2) Conversion policy premium rates may not exceed by more than 35% the index rate  
 1343 for [~~individuals~~] small employers with similar case characteristics for any class of business in  
 1344 which the policy form has been approved.

1345 (3) An insurer may not consider pregnancy of a covered insured in determining its  
 1346 conversion policy premium rates.

1347 Section 18. Section **31A-30-202** is amended to read:

1348 **31A-30-202. Definitions.**

1349 For purposes of this part:

1350 (1) "Defined benefit plan" means an employer group health benefit plan in which:

1351 (a) the employer selects the health benefit plan or plans from a single insurer;

1352 (b) employees are not provided a choice of health benefit plans on the Health Insurance  
 1353 Exchange; and

1354 (c) the employer is subject to contribution requirements in Section 31A-30-112.

1355 [~~(1)~~] (2) "Defined contribution arrangement":

1356 (a) means a defined contribution arrangement employer group health benefit plan that:

1357 [~~(a)~~] (i) complies with this part; and

1358 [~~(b)~~] (ii) is sold through the [~~Internet portal~~] Health Insurance Exchange in accordance  
 1359 with Title 63M, Chapter 1, Part 25, Health System Reform Act[?]; and

1360 (b) beginning January 1, 2011, includes an employer choice of either a defined

1361 contribution arrangement health benefit plan or a defined benefit plan offered through the  
1362 Health Insurance Exchange.

1363 [~~2~~] (3) "Health reimbursement arrangement" means an employer provided health  
1364 reimbursement arrangement in which reimbursements for medical care expenses are excluded  
1365 from an employee's gross income under the Internal Revenue Code.

1366 [~~3~~] (4) "Producer" is as defined in Subsection 31A-23a-501(4)(a).

1367 [~~4~~] (5) "Section 125 Cafeteria plan" means a flexible spending arrangement that  
1368 qualifies under Section 125, Internal Revenue Code, which permits an employee to contribute  
1369 pre-tax dollars to a health benefit plan.

1370 [~~5~~] (6) "Small employer" is defined in Section 31A-1-301.

1371 Section 19. Section **31A-30-202.5** is enacted to read:

1372 **31A-30-202.5. Insurer participation in defined contribution arrangement market.**

1373 (1) A small employer carrier who chooses to participate in the defined contribution  
1374 arrangement market:

1375 (a) shall offer the defined contribution arrangement health benefit plans required by  
1376 Section 31A-30-205;

1377 (b) may:

1378 (i) offer additional defined contribution arrangement health benefit plans in the Health  
1379 Insurance Exchange as permitted by Section 31A-30-205;

1380 (ii) offer a defined benefit plan in the Health Insurance Exchange if the small employer  
1381 carrier offers a defined contribution arrangement health benefit plan that is actuarially  
1382 equivalent to the defined benefit plan that is offered in the Health Insurance Exchange; and

1383 (iii) continue to offer defined benefit plans outside of the Health Insurance Exchange,  
1384 and the defined contribution arrangement market, if the carrier uses the same rating and  
1385 underwriting practices in both the defined contribution arrangement market in the Health  
1386 Insurance Exchange and the defined benefit market outside the Health Insurance Exchange.

1387 (2) A carrier that does not elect to participate in the defined contribution arrangement  
1388 market by January 1, 2011, may not participate in the defined contribution arrangement market  
1389 in the Health Insurance Exchange until January 1, 2013.

1390 Section 20. Section **31A-30-203** is amended to read:

1391 **31A-30-203. Eligibility for defined contribution arrangement market --**

1392 **Enrollment.**

1393 (1) (a) ~~[Beginning January 1, 2010, and during the open enrollment period described in~~  
 1394 ~~Section 31A-30-208, an] An eligible small employer may choose to ~~[participate in]~~ participate  
 1395 in:~~

1396 (i) the defined contribution arrangement market in the Health Insurance Exchange  
 1397 under this part; or

1398 (ii) the traditional defined benefit market under Part 1, Individual and Small Employer  
 1399 Group.

1400 (b) A small employer may choose to offer its employees one of the following through  
 1401 the defined contribution arrangement market in the Health Insurance Exchange:

1402 (i) a defined contribution arrangement health benefit plan; or

1403 (ii) a defined benefit plan.

1404 (c) (i) Beginning January 1, 2011, and during the enrollment period, an eligible large  
 1405 employer participating in the demonstration project under Subsection 31A-30-208(1)(c) may  
 1406 choose to offer its employees a defined contribution arrangement health benefit plan.

1407 ~~[(b)]~~ (ii) Beginning January 1, 2012, [and during the open enrollment period described  
 1408 in Section 31A-30-208,] an eligible large employer may choose to [participate in] offer its  
 1409 employees a defined contribution arrangement health benefit plan.

1410 ~~[(c)]~~ (d) Defined contribution arrangement health benefit plans are employer group  
 1411 health plans individually selected by an employee of an employer.

1412 (2) (a) Participating insurers~~[-(f)]~~ shall offer to accept all eligible employees of an  
 1413 employer described in Subsection (1), and their dependents, at the same level of benefits as  
 1414 anyone else who has the same health benefit plan in the defined contribution arrangement  
 1415 market~~[-and]~~ on the Health Insurance Exchange.

1416 ~~[(ii) may not impose a premium surcharge under Section 31A-30-106.7 in the defined~~  
 1417 ~~contribution market.]~~

1418 (b) A participating insurer may:

1419 (i) request an employer to submit a copy of the employer's quarterly wage list to  
 1420 determine whether the employees for whom coverage is provided or requested are bona fide  
 1421 employees of the employer; and

1422 (ii) deny or terminate coverage if the employer refuses to provide documentation

1423 requested under Subsection (2)(b)(i).

1424 Section 21. Section **31A-30-204** is amended to read:

1425 **31A-30-204. Employer election -- Defined benefit -- Defined contribution**  
1426 **arrangements -- Responsibilities.**

1427 (1) (a) An employer participating in the defined contribution arrangement market on  
1428 the Health Insurance Exchange shall make an initial election to offer its employees either a  
1429 defined benefit plan or a defined contribution arrangement health benefit plan.

1430 (b) If an employer elects to offer a defined benefit plan:

1431 (i) the employer or the employer's producer shall enroll the employer in the Health  
1432 Insurance Exchange;

1433 (ii) the employees shall submit the uniform application required for the Health  
1434 Insurance Exchange; and

1435 (iii) the employer shall select the defined benefit plan in accordance with Section  
1436 31A-30-208.

1437 (c) When an employer makes an election under Subsections (1)(a) and (b):

1438 (i) the employer may not offer its employees a defined contribution arrangement health  
1439 benefit plan; and

1440 (ii) the employees may not select a defined contribution arrangement health benefit  
1441 plan in the Health Insurance Exchange.

1442 (d) If an employer elects to offer its employees a defined contribution arrangement  
1443 health benefit plan, the employer shall comply with the provisions of Subsections (2) through  
1444 (5).

1445 ~~[(1)]~~ (2) (a) (i) An employer [described in Subsection 31A-30-203(1)] that chooses to  
1446 participate in a defined contribution arrangement health benefit plan may not offer to an  
1447 employee a [major-medical] health benefit plan that is not a [part-of-the] defined contribution  
1448 arrangement [to-an-employee] health benefit plan in the Health Insurance Exchange.

1449 (ii) Subsection ~~[(1)]~~ (2)(a)(i) does not prohibit the offer of supplemental or limited  
1450 benefit policies such as dental or vision coverage, or other types of federally qualified savings  
1451 accounts for health care expenses.

1452 (b) (i) To the extent permitted by Sections 31A-1-301, 31A-30-112, and 31A-30-206,  
1453 and the risk adjustment plan adopted under Section ~~[31A-42-202]~~ 31A-42-204, the employer

1454 reserves the right to determine:

1455 (A) the criteria for employee eligibility, enrollment, and participation in the employer's  
1456 health benefit plan; and

1457 (B) the amount of the employer's contribution to that plan.

1458 (ii) The determinations made under Subsection ~~[(1)]~~ (2)(b) may only be changed  
1459 during periods of open enrollment.

1460 ~~[(2)]~~ (3) An employer that chooses to establish a defined contribution arrangement  
1461 health benefit plan to provide a health benefit plan for its employees shall:

1462 (a) establish a mechanism for its employees to use pre-tax dollars to purchase a health  
1463 benefit plan from the defined contribution arrangement market on the ~~[Internet portal]~~ Health  
1464 Insurance Exchange created in Section 63M-1-2504, which may include:

1465 (i) a health reimbursement arrangement;

1466 (ii) a Section 125 Cafeteria plan; or

1467 (iii) another plan or arrangement similar to Subsection ~~[(2)]~~ (3)(a)(i) or (ii) which is  
1468 excluded or deducted from gross income under the Internal Revenue Code;

1469 (b) ~~[by November 10 of the open enrollment period]~~ before the employee's health  
1470 benefit plan selection period:

1471 (i) inform each employee of the health benefit plan the employer has selected as the  
1472 default health benefit plan for the employer group;

1473 (ii) offer each employee a choice of any of the defined contribution arrangement health  
1474 benefit plans available through the defined contribution arrangement market on the ~~[Internet~~  
1475 ~~portal]~~ Health Insurance Exchange; and

1476 (iii) notify the employee that the employee will be enrolled in the default health benefit  
1477 plan selected by the employer and payroll deductions initiated for premium payments, unless  
1478 the employee, ~~[prior to November 25 of the open enrollment period]~~ before the employee's  
1479 selection period ends:

1480 (A) ~~[notifies the employer that the employee has selected]~~ selects a different defined  
1481 contribution arrangement health benefit plan available ~~[through the defined contribution~~  
1482 ~~arrangement]~~ in the ~~[Internet portal]~~ Health Insurance Exchange;

1483 (B) provides proof of coverage from another health benefit plan; or

1484 (C) specifically declines coverage in a health benefit plan.

1485           ~~[(3)]~~ (4) An employer shall enroll an employee in the default defined contribution  
 1486 arrangement health benefit plan selected by the employer if the employee does not make one of  
 1487 the choices described in Subsection ~~[(2)(b)(ii)]~~ prior to November 25 of the open enrollment  
 1488 period ~~(3)(b)(iii) before the end of the employee selection period, which may not be less than~~  
 1489 14 calendar days.

1490           ~~[(4)]~~ (5) The employer's notice to the employee under Subsection ~~[(2)]~~ (3)(b)(iii) shall  
 1491 inform the employee that the failure to act under Subsections ~~[(2)]~~ (3)(b)(iii)(A) through (C) is  
 1492 considered an affirmative election under pre-tax payroll deductions for the employer to begin  
 1493 payroll deductions for health benefit plan premiums.

1494           Section 22. Section **31A-30-205** is amended to read:

1495           **31A-30-205. Health benefit plans offered in the defined contribution market.**

1496           (1) An insurer who ~~[chooses to offer a health benefit plan in the]~~ offers a defined  
 1497 contribution ~~[market must]~~ arrangement health benefit plan shall offer the following health  
 1498 benefit plans as defined contribution arrangements:

1499           ~~[(a) one health benefit plan that:]~~

1500           ~~[(i) is a federally qualified high deductible health plan;]~~

1501           ~~[(ii) has the lowest deductible permitted for a federally qualified high deductible health~~  
 1502 plan as adjusted by federal law; and]

1503           ~~[(iii) does not exceed annual out-of-pocket maximum equal to three times the amount~~  
 1504 of the annual deductible; and]

1505           (a) the basic benefit plan;

1506           (b) one health benefit plan with ~~[benefits that have]~~ an aggregate actuarial value at least  
 1507 15% greater ~~[that] than~~ the ~~[plan described in Subsection (1)(a).]~~ actuarial value of the basic  
 1508 benefit plan; ~~H→~~ [and]

1508a           (c) one health benefit plan that is a federally qualified high deductible health plan that  
 1508b has an individual deductible of \$2,500 and a deductible of \$5,000 for coverage including two or  
 1508c more individuals, and has an out of pocket maximum equal to the level of the deductible;

1509           ~~[(e)]~~ (d) ~~←H~~ one health benefit plan that ~~H→~~ [f] is [f] a federally qualified  
 1509a1 high deductible health plan that has the highest deductible that qualifies as ←H a  
 1509a federally qualified high deductible health plan H→ [that

1510 has a deductible of \$5,000] as adjusted by federal law, ←H and does not exceed an annual  
 1510a out-of-pocket maximum H→ [of \$15,000.] equal to three times the amount of the annual  
 1510b deductible ; and

1510c           (e) the insurer's five most commonly selected health benefit plans that:

- 1510d (i) include:
- 1510e (A) the provider panel;
- 1510f (B) the deductible;
- 1510g (C) co-payments;
- 1510h (D) co-insurance; and
- 1510i (E) pharmacy benefits ; and
- 1510j (ii) have the largest number of enrolled lives in the insurer's own total block of small
- 1510k employer group business in the state. ←H

1511 (2) (a) The provisions of Subsection (1) do not limit the number of defined  
1512 contribution arrangements health benefit plans an insurer may offer in the defined contribution  
1513 arrangement market.

1514 (b) An insurer who offers the health benefit plans required by Subsection (1) may also  
1515 offer any other health benefit plan [~~in the~~] as a defined contribution [~~market~~] arrangement if:

- 1516 (i) the health benefit plan provides benefits that are ~~[actuarially richer]~~ of greater  
 1517 actuarial value than the benefits required in [Subsection (1)(a):] the basic benefit plan; or  
 1518 (ii) the health benefit plan provides benefits with an aggregate actuarial value that is no  
 1519 lower than the actuarial value of the plan required in Subsection (1)(c).

1520 Section 23. Section **31A-30-207** is amended to read:

1521 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**  
 1522 **contribution market.**

1523 (1) The rating and underwriting restrictions for defined benefit plans and for the  
 1524 defined contribution [market] arrangement health benefit plans offered in the Health Insurance  
 1525 Exchange defined contribution arrangement market shall be:

- 1526 (a) for small employer groups, in accordance with Section 31A-30-106.1;  
 1527 (b) for large employer groups, as determined by the risk adjuster board for participation  
 1528 in the risk adjustment mechanism under Chapter 42, Defined Contribution Risk Adjuster Act;  
 1529 and

1530 (c) established in accordance with the plan adopted under Chapter 42, Defined  
 1531 Contribution Risk Adjuster Act[; and shall apply to employers who participate in the defined  
 1532 contribution arrangement market].

1533 (2) All insurers who participate in the defined contribution market ~~[must]~~ shall:

- 1534 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined  
 1535 Contribution Risk Adjuster Act[-] for all defined contribution arrangement health benefit plans;

1536 ~~H→ [and] ←H~~

1537 (b) provide the risk adjuster board with:

- 1538 (i) an employer group's risk factor; and  
 1539 (ii) carrier enrollment data H→ ; and

1539a (c) submit rates to the exchange that are net of commissions ←H .

1540 (3) When an employer group of any size enters the defined contribution arrangement  
 1541 market for either a defined contribution arrangement health benefit plan, or a defined benefit  
 1542 plan, and the employer group has a health plan with an insurer who is participating in the  
 1543 defined contribution arrangement market, the risk factor applied to the employer group when it  
 1544 enters the defined contribution market may not be greater than the employer group's renewal  
 1545 risk factor for the same group of covered employees and the same effective date, as determined  
 1546 by the employer group's insurer.

1547 Section 24. Section **31A-30-208** is repealed and reenacted to read:

1548 **31A-30-208. Enrollment for defined contribution arrangements.**

1549 (1) An insurer offering a health benefit plan in the defined contribution arrangement  
1550 market:

1551 (a) beginning on or after January 1, 2011, shall allow an employer to enroll in a small  
1552 employer defined contribution arrangement plan;

1553 (b) may not impose a surcharge under Section 31A-30-106.7 for a small employer  
1554 group selecting a defined contribution arrangement health benefit plan on or before January 1,  
1555 2012;

1556 (c) shall offer a limited pilot program in which a large employer group may enroll in a  
1557 defined contribution arrangement market plan that takes effect January 1, 2011;

1558 (d) beginning January 1, 2012, shall allow a large employer group to enroll in the  
1559 defined contribution arrangement market; and

1560 (e) shall otherwise comply with the requirements of this part, Chapter 42, Defined  
1561 Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

1562 (2) (a) Except as provided in Subsection 31A-30-202.5(2), in accordance with  
1563 Subsection (2)(b) of this section, on January 1 of each year, an insurer may enter or exit the  
1564 defined contribution arrangement market.

1565 (b) An insurer may offer new or modify existing products in the defined contribution  
1566 arrangement market ~~H~~→ :

1566a (i) ~~H~~ on January 1 of each year ~~H~~→ [~~and~~] ;

1566b (ii) when required by changes in other law; and

1566c (iii) ~~H~~ at other times as established by the risk

1567 adjuster board created in Section 31A-42-201.

1568 (c) (i) An insurer shall give the department, the Health Insurance Exchange, and the  
1569 risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a)  
1570 or (b).

1571 (ii) When an insurer elects to participate in the defined contribution arrangement  
1572 market, the insurer shall participate in the defined contribution arrangement market for no less  
1573 than two years.

1574 Section 25. Section **31A-30-209** is enacted to read:

1575 **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**

1576 (1) A producer may be listed on the Health Insurance Exchange as a producer for the  
1577 defined contribution arrangement market in accordance with Section 63M-1-2504, if the

1578 producer is designated as an appointed agent for the defined contribution arrangement market  
1579 in accordance with Subsection (2).

1580 (2) A producer whose license under this title authorizes the producer to sell defined  
1581 contribution arrangement health benefit plans may be appointed to the defined contribution  
1582 arrangement market on the Health Insurance Exchange by the Insurance Department, if the  
1583 producer:

1584 (a) submits an application to the Insurance Department to be appointed as a producer  
1585 for the defined contribution arrangement market on the Health Insurance Exchange;

1586 (b) is an appointed agent with the majority of the carriers that offer a defined  
1587 contribution arrangement health benefit plan on the Health Insurance Exchange; and

1588 (c) has completed a defined contribution arrangement training session that is an  
1589 approved training session as designated by the commissioner.

1590 Section 26. Section **31A-42-102** is amended to read:

1591 **31A-42-102. Definitions.**

1592 As used in this chapter:

1593 (1) "Board" means the board of directors of the Utah Defined Contribution Risk  
1594 Adjuster created in Section 31A-42-201.

1595 (2) "Defined benefit plan" is as defined in Section 31A-30-202.

1596 [(2)] (3) "Risk adjuster" means the defined contribution risk adjustment mechanism  
1597 created in Section 31A-42-201.

1598 Section 27. Section **31A-42-103** is amended to read:

1599 **31A-42-103. Applicability and scope.**

1600 This chapter applies to a carrier as defined in Section 31A-30-103 who offers a defined  
1601 contribution arrangement health benefit plan [~~in a defined contribution arrangement~~] under  
1602 Chapter 30, Part 2, Defined Contribution Arrangements.

1603 Section 28. Section **31A-42-201** is amended to read:

1604 **31A-42-201. Creation of risk adjuster mechanism -- Board of directors --**  
1605 **Appointment -- Terms -- Quorum -- Plan preparation.**

1606 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity  
1607 within the [~~Insurance Department~~] department.

1608 (2) (a) The risk adjuster [~~shall be~~] is under the direction of a board of directors

1609 composed of up to nine members described in Subsection (2)(b).

1610 (b) ~~[The following directors shall be]~~ The board of directors shall consist of:

1611 (i) the following directors appointed by the governor with the consent of the Senate:

1612 ~~[(i)]~~ (A) at least three, but up to five, directors with actuarial experience who represent

1613 ~~[insurance carriers]~~ insurers:

1614 ~~[(A)]~~ (I) that are participating or have committed to participate in the defined

1615 contribution arrangement market in the state; and

1616 ~~[(B)]~~ (II) including at least one and up to two directors who represent ~~[a carrier]~~ an

1617 insurer that has a small percentage of lives in the defined contribution market;

1618 ~~[(ii)]~~ (B) one director who represents either an individual employee or employer

1619 ~~[participant in the defined contribution market]; and~~

1620 ~~[(iii)]~~ (C) one director ~~[appointed by the governor to represent]~~ who represents the

1621 Office of Consumer Health Services within the Governor's Office of Economic Development;

1622 ~~[(iv)]~~ (ii) one director representing the ~~[Public Employee's Health Benefit Program]~~

1623 Public Employees' Benefit and Insurance Program with actuarial experience, chosen by the

1624 director of the ~~[Public Employee's Health Benefit Program who shall serve as an ex officio~~

1625 ~~member]~~ Public Employees' Benefit and Insurance Program; and

1626 ~~[(v)]~~ (iii) the commissioner, or a representative ~~[from the department with actuarial~~

1627 ~~experience]~~ of the commissioner who:

1628 (A) is appointed by the commissioner; and

1629 (B) has actuarial experience.

1630 (c) The commissioner or a representative appointed by the commissioner, ~~[who will~~

1631 ~~only have voting privileges]~~ may vote only in the event of a tie vote.

1632 (3) (a) Except as required by Subsection (3)(b), as terms of current board members

1633 appointed by the governor expire, the governor shall appoint each new member or reappointed

1634 member to a four-year term.

1635 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the

1636 time of appointment or reappointment, adjust the length of terms to ensure that the terms of

1637 board members are staggered so that approximately half of the board is appointed every two

1638 years.

1639 (4) When a vacancy occurs in the membership for any reason, the replacement shall be

1640 appointed for the unexpired term in the same manner as the original appointment was made.

1641 (5) (a) ~~[Members who are not government employees shall receive no]~~ A board  
 1642 member who is not a government employee may not receive compensation or benefits for the  
 1643 members' services.

1644 (b) A state government member who is a member because of the member's state  
 1645 government position may not receive per diem or expenses for the member's service.

1646 (6) The board shall elect annually a chair and vice chair from its membership.

1647 (7) ~~[Six]~~ ~~↔~~ [One-half] A majority ~~↔~~ of the board members ~~↔~~ [are] is ~~↔~~ a  
 1647a quorum for the transaction of business.

1648 (8) The action of a majority of the members of the quorum is the action of the board.

1649 Section 29. Section **31A-42-202** is amended to read:

1650 **31A-42-202. Contents of plan.**

1651 (1) The board shall submit a plan of operation for the risk adjuster to the  
 1652 commissioner. The plan shall:

1653 (a) establish the methodology for implementing:

1654 (i) Subsection (2) for the defined contribution arrangement market established under  
 1655 Chapter 30, Part 2, Defined Contribution Arrangements; and

1656 (ii) the participation of:

1657 (A) small employer group defined contribution arrangement health benefit plans; and

1658 (B) large employer group defined contribution arrangement health benefit plans;

1659 (b) establish regular times and places for meetings of the board;

1660 (c) establish procedures for keeping records of all financial transactions and for  
 1661 sending annual fiscal reports to the commissioner;

1662 (d) contain additional provisions necessary and proper for the execution of the powers  
 1663 and duties of the risk adjuster; and

1664 (e) establish procedures in compliance with Title 63A, Utah Administrative Services  
 1665 Code, to pay for administrative expenses incurred.

1666 (2) (a) The plan adopted by the board for the defined contribution arrangement market  
 1667 shall include:

1668 (i) parameters an employer may use to designate eligible employees for the defined  
 1669 contribution arrangement market; and

1670 (ii) underwriting mechanisms and employer eligibility guidelines:

1671 (A) consistent with the federal Health Insurance Portability and Accountability Act;  
1672 and

1673 (B) necessary to protect insurance carriers from adverse selection in the defined  
1674 contribution market.

1675 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a  
1676 qualified individual are determined, including:

1677 (i) the identification of an initial rate for a qualified individual based on:

1678 (A) standardized age bands submitted by participating insurers; and

1679 (B) wellness incentives for the individual as permitted by federal law; and

1680 (ii) the identification of a group risk factor to be applied to the initial age rate of a  
1681 qualified individual based on the health conditions of all qualified individuals in the same  
1682 employer group and, for small employers, in accordance with Sections 31A-30-105 and  
1683 ~~[31A-30-106]~~ 31A-30-106.1.

1684 (c) The plan adopted under Subsection (2)(a) shall outline how:

1685 (i) premium contributions for qualified individuals shall be submitted to the ~~[Internet~~  
1686 ~~portal]~~ Health Insurance Exchange in the amount determined under Subsection (2)(b); and

1687 (ii) the ~~[Internet portal]~~ Health Insurance Exchange shall distribute premiums to the  
1688 insurers selected by qualified individuals within an employer group based on each individual's  
1689 ~~[health risk]~~ rating factor determined in accordance with the plan.

1690 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting  
1691 risk between insurers that:

1692 (i) identifies health care conditions subject to risk adjustment;

1693 (ii) establishes an adjustment amount for each identified health care condition;

1694 (iii) determines the extent to which an insurer has more or less individuals with an  
1695 identified health condition than would be expected; and

1696 (iv) computes all risk adjustments.

1697 (e) The board may amend the plan if necessary to:

1698 (i) incorporate large group defined contribution arrangement health benefit plans into  
1699 the defined contribution arrangement market risk adjuster mechanism created by this chapter;

1700 ~~[(i)]~~ (ii) maintain the proper functioning and solvency of the defined contribution  
1701 arrangement market and the risk adjuster mechanism;

1702 ~~[(ii)]~~ (iii) mitigate significant issues of risk selection; or  
 1703 ~~[(iii)]~~ (iv) improve the administration of the risk adjuster mechanism including opening  
 1704 enrollment periodically until January 1, 2011, for the purpose of testing the enrollment and risk  
 1705 adjusting process.

1706 (3) (a) The board shall establish a mechanism in which the participating carriers shall  
 1707 submit their plan base rates, rating factors, and premiums to an independent actuary, appointed  
 1708 by the board, for review prior to the publication of the premium rates on the Health Insurance  
 1709 Exchange.

1710 (b) The actuary appointed by the board shall:

1711 (i) be compensated for the analysis under this section from fees established in  
 1712 accordance with Section 63J-1-504:

1713 (A) assessed by the board; and

1714 (B) paid by all small employer carriers participating in the defined contribution

1715 arrangement market and small employer carriers offering health benefit plans under ~~H~~→ **Chapter**  
 1715a **30, ←~~H~~** Part 1,

1716 ~~H~~→ ~~[Defined Contribution Risk Adjuster Act]~~ **Individual, Small Employer and Group Health**

1716a **Insurance Act ←~~H~~** ; and

1717 (ii) review the information submitted:

1718 (A) under Subsection (3)(a) for the purpose of verifying the validity of the rates, rating  
 1719 factors, and premiums; and

1720 (B) from carriers offering health benefit plans under ~~H~~→ **Chapter 30, ←~~H~~** Part 1,

1720a ~~H~~→ ~~[Defined Contribution Risk~~

1721 ~~Adjuster Act]~~ **Individual, Small Employer and Group Health Insurance Act ←~~H~~** :

1722 (I) for the purpose of verifying underwriting and rating practices; and

1723 (II) as the actuary determines is necessary.

1724 (c) Fees collected under Subsection (3)(b) shall be used to pay the actuary for the  
 1725 purpose of overseeing market conduct.

1726 (d) The actuary shall:

1727 (i) report aggregate data to the risk adjuster board;

1728 (ii) contact carriers:

1729 (A) to inform a carrier of the actuary's findings regarding the particular carrier; and

1730 (B) to request a carrier to re-calculate or verify base rates, rating factors, and

1731 premiums; and

1732 (iii) share the actuary's analysis and data with the department for the purposes

1733 described in Section 31A-30-106.1.

1734 (e) A carrier shall re-submit premium rates if the ~~H→~~ [actuary or the] ~~←H~~ department  
1734a contacts the

1735 carrier under Subsection (3) ~~H→~~ [(c)] ~~←H~~ .

1736 Section 30. Section **31A-42a-101** is enacted to read:

1737 **CHAPTER 42a. UTAH STATEWIDE RISK ADJUSTER ACT**

1738 **31A-42a-101. Title.**

1739 This chapter is known as the "Utah Statewide Risk Adjuster Act."

1740 Section 31. Section **31A-42a-102** is enacted to read:

1741 **31A-42a-102. Definitions.**

1742 As used in this chapter:

1743 (1) "Board" means the Utah Statewide Risk Adjuster Board created in Section  
1744 31A-42a-201.

1745 (2) "Carrier" has the same meaning as defined in Section 31A-30-103.

1746 Section 32. Section **31A-42a-103** is enacted to read:

1747 **31A-42a-103. Applicability and scope.**

1748 This chapter applies:

1749 (1) to a carrier that offers a health benefit plan in a defined contribution arrangement  
1750 under Chapter 30, Part 2, Defined Contribution Arrangements; and

1751 (2) any health benefit plan offered to a small employer group on or after January  
1752 1,2011, including a plan offered to a small employer group not participating in a defined  
1753 contribution arrangement.

1754 Section 33. Section **31A-42a-201** is enacted to read:

1755 **31A-42a-201. Creation of defined contribution market risk adjuster mechanism**  
1756 **-- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.**

1757 (1) There is created the "Utah Statewide Risk Adjuster," a nonprofit entity within the  
1758 Insurance Department.

1759 (2) (a) There is created the Utah Statewide Risk Adjuster Board composed of up to nine  
1760 members described in Subsection (2)(b).

1761 (b) The board of directors shall consist of:

1762 (i) the following directors appointed by the governor with the consent of the Senate:

1763 (A) at least three, but up to five, directors with actuarial experience who represent

- 1764 insurance carriers:
- 1765 (I) that are participating or have committed to participate in the defined contribution
- 1766 arrangement market in the state; and
- 1767 (II) including at least one and up to two directors who represent a carrier that has a
- 1768 small percentage of lives in the defined contribution market;
- 1769 (B) one director who represents either an individual employee or employer; and
- 1770 (C) one director who represents the Office of Consumer Health Services within the
- 1771 Governor's Office of Economic Development;
- 1772 (ii) one director representing the Public Employee's Health Program with actuarial
- 1773 experience, chosen by the director of the Public Employee's Health Program; and
- 1774 (iii) the commissioner, or a representative of the commissioner who:
- 1775 (A) is appointed by the commissioner; and
- 1776 (B) has actuarial experience.
- 1777 (c) The commissioner or a representative appointed by the commissioner, may vote
- 1778 only in the event of a tie vote.
- 1779 (3) (a) Except as required by Subsection (3)(b), as terms of current board members
- 1780 appointed by the governor expire, the governor shall appoint each new member or reappointed
- 1781 member to a four-year term.
- 1782 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
- 1783 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
- 1784 board members are staggered so that approximately half of the board is appointed every two
- 1785 years.
- 1786 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
- 1787 appointed for the unexpired term in the same manner as the original appointment was made.
- 1788 (5) (a) Members who are not government employees shall receive no compensation or
- 1789 benefits for the members' services.
- 1790 (b) A state government member who is a member because of the member's state
- 1791 government position may not receive per diem or expenses for the member's service.
- 1792 (6) The board shall elect annually a chair and vice chair from its membership.
- 1793 (7) Six board members are a quorum for the transaction of business.
- 1794 (8) The action of a majority of the members of the quorum is the action of the board.

1795 (9) The commissioner may designate an executive secretary from the department to  
 1796 provide administrative assistance to the board in carrying out its responsibilities.

1797 (10) (a) The Utah Statewide Risk Adjuster operates under the direction of the board in  
 1798 accordance with rules adopted by the commissioner under Section 31A-42a-204.

1799 (b) The budget for operation of the Utah Statewide Risk Adjuster is subject to the  
 1800 approval of the board.

1801 Section 34. Section **31A-42a-202** is enacted to read:

1802 **31A-42a-202. Contents of plan.**

1803 (1) The Utah Statewide Risk Adjuster Board shall submit to the commissioner a  
 1804 proposed plan of operation for the Utah Statewide Risk Adjuster. The proposed plan of  
 1805 operation shall:

1806 (a) specify how the Utah Statewide Risk Adjuster shall adjust risk for:

1807 (i) the defined contribution arrangement market established under Chapter 30, Part 2,  
 1808 Defined Contribution Arrangements; and

1809 (ii) any health benefit plan offered to a small employer group on or after January 1,  
 1810 ~~H~~→ [2011] 2013 ←~~H~~, including a plan offered to a small employer group not participating in a  
 1810a defined

1811 contribution arrangement;

1812 (b) establish regular times and places for meetings of the board;

1813 (c) establish procedures for keeping records of all financial transactions and for  
 1814 sending annual fiscal reports to the commissioner;

1815 (d) contain additional provisions necessary and proper for the execution of the powers  
 1816 and duties of the Utah Statewide Risk Adjuster; and

1817 (e) establish procedures in compliance with Title 63A, Utah Administrative Services  
 1818 Code, to pay for administrative expenses incurred.

1819 (2) The proposed plan of operation under Subsection (1) shall include:

1820 (a) for the defined contribution arrangement market:

1821 (i) parameters an employer may use to designate eligible employees for the defined  
 1822 contribution arrangement market;

1823 (ii) employer eligibility guidelines that protect carriers from adverse selection in the  
 1824 defined contribution market; and

1825 (iii) (A) how premium contributions for qualified individuals shall be submitted to the

1826 Internet portal in the amount determined under Subsection (2)(b); and

1827 (B) how the Internet portal shall distribute premiums to the carriers selected by  
 1828 qualified individuals within an employer group based on each individual's health risk factor  
 1829 determined in accordance with the plan;

1830 (b) for the defined contribution arrangement market and for any health benefit plan  
 1831 offered to a small employer group on or after January 1, ~~H~~→ [2011] 2013 ←~~H~~ , including a plan  
 1831a offered to a  
 1832 small employer group not participating in a defined contribution arrangement;

1833 (i) underwriting mechanisms:

1834 (A) consistent with the federal Health Insurance Portability and Accountability Act;

1835 and

1836 (B) necessary to protect carriers from adverse selection;

1837 (ii) how premium rates for an enrollee are calculated, including:

1838 (A) calculation of an initial rate for an enrollee based on:

1839 (I) standardized age bands submitted by carriers; and

1840 (II) wellness incentives for the individual as permitted by federal law; and

1841 (B) calculation of a group risk factor to be applied to the initial age rate based on the  
 1842 health conditions of all qualified individuals in the same employer group and, for small

1843 employer groups, in accordance with Sections 31A-30-105 and 31A-30-106; and

1844 (iii) a mechanism for adjusting risk among carriers that:

1845 (A) identifies health conditions subject to risk adjustment;

1846 (B) establishes an adjustment amount for each identified health condition;

1847 (C) determines the extent to which a carrier has more or fewer individuals with an  
 1848 identified health condition than would be expected; and

1849 (D) calculates all risk adjustments.

1850 Section 35. Section **31A-42a-203** is enacted to read:

1851 **31A-42a-203. Powers and duties of board.**

1852 (1) The Utah Statewide Risk Adjuster Board may:

1853 (a) enter into contracts to carry out the provisions and purposes of this chapter,  
 1854 including, with the approval of the commissioner, contracts with persons or other organizations  
 1855 for the performance of administrative functions; and

1856 (b) sue or be sued, including taking legal action necessary to implement and enforce

1857 rules adopted under Section 31A-42a-204.

1858 (2) In addition to the requirements of Section 31A-42a-202, the Utah Statewide Risk  
 1859 Adjuster Board shall:

1860 (a) as necessary, submit to the commissioner proposed amendments to the proposed  
 1861 plan of operation under Subsection 31A-42a-202(1), and to rules adopted by the commissioner  
 1862 under Section 31A-42a-204, that:

1863 (i) maintain the proper functioning and solvency of the defined contribution  
 1864 arrangement market and promote the viability of health benefit plans offered to small employer  
 1865 groups on or after January 1, ~~H~~→ [2011] 2013 ←~~H~~ , including amendments affecting the calculation  
 1865a of rates,

1866 underwriting, and other actuarial functions;

1867 (ii) mitigate significant issues of risk selection; or

1868 (iii) improve how the Utah Statewide Risk Adjuster adjusts risk;

1869 (b) prepare and submit an annual report to the department for inclusion in the

1870 department's annual market report, which shall include:

1871 (i) the expenses incurred by the board and by the Utah Statewide Risk Adjuster;

1872 (ii) a description of the types of policies sold in the defined contribution arrangement  
 1873 market;

1874 (iii) the number of insured lives in the defined contribution arrangement market;

1875 (iv) the number of insured lives in health benefit plans that do not include state

1876 mandates; and

1877 (v) the effect of risk adjustment rules adopted under Section 31A-42a-204 on:

1878 (A) plans offered in the defined contribution arrangement market; and

1879 (B) plans offered to a small employer group on or after January 1, ~~H~~→ [2001] 2013 ←~~H~~ ;

1879a and

1880 (c) beginning in ~~H~~→ [2010] 2013 ←~~H~~ and ending in ~~H~~→ [2012] 2014 ←~~H~~ , report to the

1880a Health Reform Task Force and

1881 to the Legislative Management Committee prior to October 1 of each year regarding the board's

1882 progress in:

1883 (i) developing the plan required under Section 31A-42a-202;

1884 (ii) expanding choice of plans in the defined contribution arrangement market; and

1885 (iii) expanding access to the defined contribution arrangement market in the Internet

1886 portal for large employer groups.

1887 (3) The administrative budget of the board and the commissioner under this chapter

1888 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is  
 1889 subject to review and approval by the Legislature.

1890 Section 36. Section **31A-42a-204** is enacted to read:

1891 **31A-42a-204. Powers of commissioner.**

1892 (1) The commissioner shall, after notice and hearing, adopt the Utah Statewide Risk  
 1893 Adjuster Board's proposed plan of operation, and any amendment thereto, through  
 1894 administrative rulemaking if the commissioner determines that the plan or amendment:

1895 (a) meets the requirements of Sections 31A-42a-202 and 31A-42a-203; and

1896 (b) ensures a fair and reasonable administration of risk by the Utah Statewide Risk  
 1897 Adjuster.

1898 (2) The plan, and any amendment thereto, shall be effective only after adoption by the  
 1899 commissioner as an administrative rule in accordance with Title 63G, Chapter 3, Utah  
 1900 Administrative Rulemaking Act.

1901 (3) The commissioner shall, after notice and hearing, adopt such rules as necessary to  
 1902 effectuate the provisions of this chapter, if:

1903 (a) the board fails to submit to the commissioner a proposed plan of operation by  
 1904 January 1, ~~H~~→ [2010] 2013 ←~~H~~, addressing each of the elements specified in Section  
 1904a 31A-42a-202;

1905 (b) the board fails to submit to the commissioner by September 1, ~~H~~→ [2010] 2012 ←~~H~~,  
 1905a proposed  
 1906 amendments to rules adopted under this section to implement changes made to this chapter  
 1907 during the 2010 Annual General Session of the Legislature; or

1908 (c) the board fails to submit a proposed amendment to rules adopted under this section  
 1909 within a reasonable period, when requested to do so by the commissioner.

1910 (4) Rules promulgated by the commissioner shall continue in force until modified by  
 1911 the commissioner, by rule, or until superseded by a subsequent plan of operation, or an  
 1912 amendment to the plan of operation, submitted by the board, approved by the commissioner,  
 1913 and implemented by rule.

1913a ~~H~~→ **Section 37. Section 58-5a-307 is enacted to read:**

1913b **58-5a-307. Consumer access to provider charges.**

1913c **Beginning January 1, 2011, a podiatric physician licensed under this chapter shall,**  
 1913d **when requested by a consumer:**

1913e **(1) make a list of professional charges available for the consumer which includes the**  
 1913f **podiatric physician's 25 most frequently performed:**

- 1913g (a) clinical procedures or clinical services;
- 1913h (b) out-patient procedures; and
- 1913i (c) in-patient procedures; and
- 1913j (2) provide the consumer with information regarding any discount available for:
- 1913k (a) services not covered by insurance; or
- 1913l (b) prompt payment of billed charges. ←H
- 1914 Section 37. Section **58-31b-802** is enacted to read:
- 1915 **58-31b-802. Consumer access to provider charges.**
- 1916 Beginning January 1, 2011, a nurse whose license under this chapter authorizes
- 1917 independent practice shall, when requested by a consumer:
- 1918 (1) make a list of prices charged by the nurse available for the consumer which

1919 includes the nurse's 25 most frequently performed:

1920 (a) clinic procedures or clinic services;

1921 (b) out-patient procedures; and

1922 (c) in-patient procedures; and

1923 (2) provide the consumer with information regarding any discount available for:

1924 (a) services not covered by insurance; or

1925 (b) prompt payment of billed charges.

1926 Section 38. Section **58-67-804** is enacted to read:

1927 **58-67-804. Consumer access to provider charges.**

1928 Beginning January 1, 2011, a physician licensed under this chapter shall, when

1929 requested by a consumer:

1930 (1) make a list of prices charged by the physician available for the consumer which

1931 includes the physician's 25 most frequently performed:

1932 (a) clinic procedures or clinic services;

1933 (b) out-patient procedures; and

1934 (c) in-patient procedures; and

1935 (2) provide the consumer with information regarding any discount available for:

1936 (a) services not covered by insurance; or

1937 (b) prompt payment of billed charges.

1938 Section 39. Section **58-68-804** is enacted to read:

1939 **58-68-804. Consumer access to provider charges.**

1940 Beginning January 1, 2011, an osteopathic physician licensed under this chapter shall,

1941 when requested by a consumer:

1942 (1) make a list of prices charged by the osteopathic physician available for the

1943 consumer which includes the osteopathic physician's 25 most frequently performed:

1944 (a) clinic procedures or clinic services;

1945 (b) out-patient procedures; and

1946 (c) in-patient procedures; and

1947 (2) provide the consumer with information regarding any discount available for:

1948 (a) services not covered by insurance; or

1949 (b) prompt payment of billed charges.

1950 Section 40. Section **58-69-806** is enacted to read:

1951 **58-69-806. Consumer access to provider charges.**

1952 Beginning January 1, 2011, a dentist licensed under this chapter shall, when requested  
1953 by a consumer:

1954 (1) make a list of prices charged by the dentist available for the consumer which  
1955 includes the dentist's 25 most frequently performed:

1956 (a) clinic procedures or clinic services;

1957 (b) out-patient procedures; and

1958 (c) in-patient procedures; and

1959 (2) provide the consumer with information regarding any discount available for:

1960 (a) services not covered by insurance; or

1961 (b) prompt payment of billed charges.

1961a **H→ Section 41. Section 58-73-603 is enacted to read:**

1961b **58-73-603. Consumer access to provider charges.**

1961c **Beginning January 1, 2011, a chiropractic physician licensed under this chapter shall,**  
1961d **when requested by a consumer:**

1961e **(1) make a list of professional charges available for the consumer which includes the**  
1961f **chiropractic physician's 25 most frequently performed:**

1961g **(a) clinical procedures or clinical services;**

1961h **(b) out-patient procedures; and**

1961i **(c) in-patient procedures; and**

1961j **(2) provide the consumer with information regarding any discount available for:**

1961k **(a) services not covered by insurance; or**

1961l **(b) prompt payment of billed charges. ←H**

1961m **S→ Section 41. Section 63I-1-231 is amended to read:**

1961n **63I-1-231. Repeal dates, Title 31A.**

1961o **(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2010.**

1961p **(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.**

1961q **(3) Section 31A-22-315, Motor vehicle insurance reporting -- Penalty, is repealed July**  
1961r **1, 2010.**

1961s **(4) Section 31A-22-625, Catastrophic coverage of mental health conditions, is repealed**  
1961t **July 1, 2011.**

1961u **(5) Chapter 42a, Utah Statewide Risk Adjuster Act, is repealed July 1, 2016. ←S**

1962 Section 41. Section **63I-2-231** is amended to read:

- 1963           **63I-2-231. Repeal dates, Title 31A.**
- 1964           (1) Section 31A-23a-415 is repealed July 1, 2011.
- 1965           (2) Section 31A-22-619 is repealed July 1, 2010.
- 1966           (3) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed January
- 1967 1, 2013.
- 1968           Section 42. Section **63M-1-2504** is amended to read:
- 1969           **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
- 1970           (1) There is created within the Governor's Office of Economic Development the Office
- 1971 of Consumer Health Services.

1972           (2) The office shall:  
1973           (a) in cooperation with the Insurance Department, the Department of Health, and the  
1974 Department of Workforce Services, and in accordance with the electronic standards developed  
1975 under Sections 31A-22-635 and 63M-1-2506, create [~~an Internet portal~~] a Health Insurance  
1976 Exchange that:  
1977           (i) is capable of providing access to private and government health insurance websites  
1978 and their electronic application forms and submission procedures;  
1979           (ii) provides a consumer comparison of and enrollment in a health benefit plan posted  
1980 on the [~~Internet portal~~] Health Insurance Exchange by an insurer for the:

1981 (A) small employer group market;  
1982 (B) the individual market; and  
1983 (C) the defined contribution arrangement market; and  
1984 (iii) includes information and a link to enrollment in premium assistance programs and  
1985 other government assistance programs;  
1986 (b) facilitate a private sector method for the collection of health insurance premium  
1987 payments made for a single policy by multiple payers, including the policyholder, one or more  
1988 employers of one or more individuals covered by the policy, government programs, and others  
1989 by educating employers and insurers about collection services available through private  
1990 vendors, including financial institutions;  
1991 (c) assist employers with a free or low cost method for establishing mechanisms for the  
1992 purchase of health insurance by employees using pre-tax dollars;  
1993 (d) periodically convene health care providers, payers, and consumers to monitor the  
1994 progress being made regarding demonstration projects for health care delivery and payment  
1995 reform; ~~and~~  
1996 (e) establish a list on the Health Insurance Exchange of insurance producers who, in  
1997 accordance with Section 31A-30-209, are appointed producers for the defined contribution  
1998 arrangement market on the Health Insurance Exchange; and  
1999 ~~(e)~~ (f) report to the Business and Labor Interim Committee and the Health System  
2000 Reform Task Force prior to ~~November 1, 2009 and~~ November 1, 2010, and prior to the  
2001 Legislative interim day in November of each year thereafter regarding:  
2002 (i) the operations of the ~~[Internet portal]~~ Health Insurance Exchange required by this  
2003 chapter; and  
2004 (ii) the progress of the demonstration projects for health care payment and delivery  
2005 reform.  
2006 (3) The office:  
2007 (a) may not:  
2008 (i) regulate health insurers, health insurance plans, or health insurance producers;  
2009 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or  
2010 (iii) act as an appeals entity for resolving disputes between a health insurer and an  
2011 insured; and

2012 (b) may establish and collect a fee in accordance with Section 63J-1-504 for the  
 2013 transaction cost of:

2014 (i) processing an application for a health benefit plan from the Internet portal to an  
 2015 insurer; and

2016 (ii) accepting, processing, and submitting multiple premium payment sources.

2017 Section 43. Section **63M-1-2506** is amended to read:

2018 **63M-1-2506. Health benefit plan information on Health Insurance Exchange --**  
 2019 **Insurer transparency.**

2020 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,  
 2021 Chapter 3, Utah Administrative Rulemaking Act, that:

2022 (i) establish uniform electronic standards for:

2023 (A) a health insurer to use when:

2024 (I) transmitting information to ~~[the Internet portal; or]~~:

2025 (Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and

2026 (Bb) the Health Insurance Exchange as required by this section;

2027 (II) receiving information from the ~~[Internet portal; and]~~ Health Insurance Exchange;

2028 (III) receiving or transmitting the universal health application to or from the Health  
 2029 Insurance Exchange;

2030 (B) facilitating the transmission and receipt of premium payments from multiple  
 2031 sources in the defined contribution arrangement market; and

2032 (C) the use of the uniform health insurance application required by Section  
 2033 31A-22-635 on the Health Insurance Exchange;

2034 (ii) designate the level of detail that would be helpful for a concise consumer  
 2035 comparison of the items described in Subsections (4)~~[(a) through (d)]~~ and (5) on the ~~[Internet~~  
 2036 ~~portal]~~ Health Insurance Exchange; [and]

2037 (iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined  
 2038 Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on  
 2039 the ~~[Internet portal]~~ Health Insurance Exchange with the determination of when an employer is  
 2040 eligible to participate in the ~~[Internet portal defined contribution market]~~ Health Insurance  
 2041 Exchange under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements~~[-];~~ and

2042 (iv) create an advisory board to advise the exchange concerning the operation of the

2043 exchange and transparency issues with the following members:

2044 (A) two health producers who are registered with the Health Insurance Exchange;

2045 (B) two consumers;

2046 (C) one representative from a large insurer who participates on the exchange;

2047 (D) one representative from a small insurer who participates on the exchange; ~~H→~~[and]~~←H~~

2048 (E) one representative from the Insurance Department ~~H→~~ ; and

2048a (F) one representative from the Department of Health ~~←H~~ .

2049 (b) The office shall post or facilitate the posting of:

2050 (i) the information required by this section on the [~~Internet portal~~] Health Insurance

2051 Exchange created by this part; and

2052 (ii) links to websites that provide cost and quality information from the Department of

2053 Health Data Committee or neutral entities with a broad base of support from the provider and

2054 payer communities.

2055 (2) A health insurer shall use the uniform electronic standards when transmitting

2056 information to the [~~Internet portal~~] Health Insurance Exchange or receiving information from

2057 the [~~Internet portal~~] Health Insurance Exchange.

2058 (3) (a) (i) An insurer who participates in the defined contribution arrangement market

2059 under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans

2060 offered in [~~that~~] the defined contribution arrangement market on the [~~Internet portal~~] Health

2061 Insurance Exchange and shall comply with the provisions of this section.

2062 (ii) Beginning January 1, ~~H→~~ [2011] 2013 ~~←H~~ , an insurer who offers a health benefit plan

2062a to a small

2063 employer group in the state shall:

2064 (A) post the health benefit plans in which the insurer is enrolling new groups, on the

2065 Health Insurance Exchange; and

2066 (B) comply with the provisions of this section.

2067 (b) An insurer who offers [~~products~~] individual health benefit plans under Title 31A,

2068 Chapter 30, Part 1, Individual and Small Employer Group:

2069 (i) shall post on the Health Insurance Exchange the basic benefit plan required by

2070 Section 31A-22-613.5 [~~for individual and small employer group plans on the Internet portal if~~

2071 ~~the insurer's plans are offered to the general public~~]; and

2072 (ii) may publish on the Health Insurance Exchange any other health benefit plans that it

2073 offers [~~on the Internet portal; and~~] in the individual market.

2074 (c) An insurer who posts a health benefit plan on the Health Insurance Exchange:  
2075 ~~[(iii)]~~ (i) shall comply with the provisions of this section for every health benefit plan it  
2076 posts on the ~~[Internet portal:]~~ Health Insurance Exchange; and  
2077 (ii) may not offer products on the Health Insurance Exchange that are not health benefit  
2078 plans.

2079 (4) A health insurer shall provide the ~~[Internet portal]~~ Health Insurance Exchange with  
2080 the following information for each health benefit plan submitted to the ~~[Internet portal]~~ Health  
2081 Insurance Exchange:

2082 (a) plan design, benefits, and options offered by the health benefit plan including state  
2083 mandates the plan does not cover;

2084 (b) provider networks;

2085 (c) wellness programs and incentives; and

2086 (d) descriptions of prescription drug benefits, exclusions, or limitations~~[-; and]~~.

2087 ~~[(e) at the same time as information is submitted under Subsection 31A-30-208(2), the~~  
2088 ~~following operational measures for each health insurer that submits information to the Internet~~  
2089 ~~portal:]~~

2090 (5) (a) An insurer offering any health benefit plan in the state shall submit the  
2091 information described in Subsection (5)(b) to the Insurance Department in the electronic format  
2092 required by Subsection (1).

2093 (b) An insurer who offers a health benefit plan in the state shall submit to the Health  
2094 Insurance Exchange the following operational measures:

2095 (i) the percentage of claims paid by the insurer within 30 days of the date a claim is  
2096 submitted to the insurer for the prior year; and

2097 ~~[(ii) the number of adverse benefit determinations by the insurer which were~~  
2098 ~~subsequently overturned on independent review under Section 31A-22-629 as a percentage of~~  
2099 ~~total claims paid by the insurer for the prior year:]~~

2100 (ii) for all health benefit plans offered by the insurer in the state, the claims denial and  
2101 insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).

2102 (c) The Insurance Department shall forward to the Health Insurance Exchange the  
2103 information submitted by an insurer in accordance with this section and Section 31A-22-613.5.

2104 ~~[(5)]~~ (6) The Insurance Department shall post on the ~~[Internet portal]~~ Health Insurance

2105 Exchange the Insurance Department's solvency rating for each insurer who posts a health  
2106 benefit plan on the [~~Internet portal~~] Health Insurance Exchange. The solvency rating for each  
2107 carrier shall be based on methodology established by the Insurance Department by  
2108 administrative rule and shall be updated each calendar year.

2109 [~~(6)~~] (7) The commissioner may request information from an insurer under Section  
2110 31A-22-613.5 to verify the data submitted to the [~~Internet portal~~] Insurance Department and to  
2111 the Health Insurance Exchange under this section.

2112 [~~(7)~~] (8) A health insurer shall accept and process an application for a health benefit  
2113 plan from the [~~Internet portal~~] Health Insurance Exchange in accordance with this section and  
2114 Section 31A-22-635.

2115 Section 44. **Health System Reform Task Force -- Creation -- Membership --**  
2116 **Interim rules followed -- Compensation -- Staff.**

2117 (1) There is created the Health System Reform Task Force consisting of the following  
2118 11 members:

2119 (a) four members of the Senate appointed by the president of the Senate, no more than  
2120 three of whom may be from the same political party; and

2121 (b) seven members of the House of Representatives appointed by the speaker of the  
2122 House of Representatives, no more than five of whom may be from the same political party.

2123 (2) (a) The president of the Senate shall designate a member of the Senate appointed  
2124 under Subsection (1)(a) as a co-chair of the committee.

2125 (b) The speaker of the House of Representatives shall designate a member of the House  
2126 of Representatives appointed under Subsection (1)(b) as a co-chair of the committee.

2127 (3) In conducting its business, the committee shall comply with the rules of legislative  
2128 interim committees.

2129 (4) Salaries and expenses of the members of the committee shall be paid in accordance  
2130 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage  
2131 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override  
2132 Sessions.

2133 (5) The Office of Legislative Research and General Counsel shall provide staff support  
2134 to the committee.

2135 Section 45. **Duties -- Interim report.**

2136 (1) The committee shall review and make recommendations on the following issues:

2137 (a) the state's progress in implementing the strategic plan for health system reform as  
2138 described in Section 63M-1-2505;

2139 (b) the implementation of statewide demonstration projects to provide systemwide  
2140 aligned incentives for the appropriate delivery of and payment for health care;

2141 (c) the development of the defined contribution arrangement market and the plan  
2142 developed by the risk adjuster board for implementation by January 1, 2012, including:

2143 (i) consumer experience and plan selection in the defined contribution market;

2144 (ii) participation by large employer groups in the defined contribution market; and

2145 (iii) risk allocation in the defined contribution market including the study of  
2146 implementing an individual health risk score;

2147 (d) the operations and progress of the Health Insurance Exchange;

2148 (e) mechanisms to increase transparency in the insurance market;

2149 (f) the implementation and effectiveness of insurer wellness programs and incentives,  
2150 including outcome measures for the programs;

2151 (g) developing with providers and insurers a more efficient process for  
2152 pre-authorization from an insurer for a medical procedure;

2153 (h) the role that the Public Employees' Benefit and Insurance Program and other  
2154 associations that provide insurance may play in the defined contribution market;

2155 (i) the development of strategies to keep community leaders, business leaders, and the  
2156 public involved in the process of health care reform; and

2157 (j) the state's response to, and duties under federal health care reform.

2158 (2) A final report shall be presented to the Business and Labor Interim Committee  
2159 before November 30, 2010.

2160 Section 46. **Effective date.**

2161 (1) Except as provided in ~~H~~→ [Subsection (2)] Subsections (2) and (3) ←~~H~~, if approved  
2161a by two-thirds of all the members

2162 elected to each house, this bill takes effect upon approval by the governor, or the day following  
2163 the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's  
2164 signature, or in the case of a veto, the date of veto override, except that the amendments to  
2165 Sections 31A-30-103 and 31A-30-106 take effect on January 1, 2011.

2165a ~~H~~→ (2) The amendments to Section 31A-3-304 (Effective 07/01/10) take effect July 1, 2010.

2166 ~~[(2)] (3) ←~~H~~~~ The following sections take effect on January 1, 2013:

- 2167        (a) Section 31A-42a-101;
- 2168        (b) Section 31A-42a-102;
- 2169        (c) Section 31A-42a-103;
- 2170        (d) Section 31A-42a-201;
- 2171        (e) Section 31A-42a-202;
- 2172        (f) Section 31A-42a-203; and
- 2173        (g) Section 31A-42a-204.

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**Legislative Review Note**  
**as of 2-3-10 3:46 PM**

**Office of Legislative Research and General Counsel**

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**H.B. 294 - Health System Reform Amendments**

**Fiscal Note**

2010 General Session

State of Utah

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**State Impact**

Enactment of this bill will require a General Fund appropriation of \$125,000 in FY 2011 and \$150,000 beginning in FY 2012 for staff support at the Department of Insurance. It will also require a one-time \$150,000 appropriation from restricted funds for software development. Actuarial costs of \$150,000 per year will be offset by fees established in the bill.

	<u>FY 2010</u> <u>Approp.</u>	<u>FY 2011</u> <u>Approp.</u>	<u>FY 2012</u> <u>Approp.</u>	<u>FY 2010</u> <u>Revenue</u>	<u>FY 2011</u> <u>Revenue</u>	<u>FY 2012</u> <u>Revenue</u>
General Fund	\$0	\$150,000	\$150,000	\$0	\$0	\$0
General Fund, One-Time	\$0	(\$25,000)	\$0	\$0	\$0	\$0
Dedicated Credits	\$0	\$150,000	\$150,000	\$0	\$150,000	\$150,000
Restricted Funds	\$0	\$150,000	\$0	\$0	\$0	\$0
<b>Total</b>	<b>\$0</b>	<b>\$425,000</b>	<b>\$300,000</b>	<b>\$0</b>	<b>\$150,000</b>	<b>\$150,000</b>

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**Individual, Business and/or Local Impact**

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for local governments. Businesses and individuals may benefit from this change in statute.