COMPREHENSIVE HEALTH INSURANCE POOL AMENDMENTS

2003 GENERAL SESSION

STATE OF UTAH

This act modifies the Comprehensive Health Insurance Pool Act. The act amends definitions. The act amends the number of board members required for a quorum, the powers of the board, and the duties of the pool administrator. The act amends eligibility for the pool and the application of preexisting conditions in order to be in compliance with federal law and to incorporate provisions of the Primary Care Network waiver for the state Medicaid program. The act amends provisions related to co-pays, deductibles, and cancellations of coverage. The act amends the frequency with which premiums may be adjusted. The act amends benefit reduction and immunity provisions. The act makes technical changes.

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-29-103, as last amended by Chapters 9 and 116, Laws of Utah 2001

31A-29-104, as last amended by Chapter 176, Laws of Utah 2002

31A-29-106, as enacted by Chapter 232, Laws of Utah 1990

31A-29-107, as enacted by Chapter 232, Laws of Utah 1990

31A-29-109, as enacted by Chapter 232, Laws of Utah 1990

31A-29-110, as enacted by Chapter 232, Laws of Utah 1990

31A-29-111, as last amended by Chapter 114, Laws of Utah 2000

31A-29-112, as last amended by Chapter 265, Laws of Utah 1997

31A-29-113, as last amended by Chapter 308, Laws of Utah 2002

31A-29-114, as enacted by Chapter 232, Laws of Utah 1990

31A-29-115, as repealed and reenacted by Chapter 265, Laws of Utah 1997

31A-29-117, as last amended by Chapter 116, Laws of Utah 2001

31A-29-119, as enacted by Chapter 232, Laws of Utah 1990

31A-29-120, as last amended by Chapter 265, Laws of Utah 1997

31A-29-122, as enacted by Chapter 232, Laws of Utah 1990

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

Section 1. Section **31A-29-103** is amended to read:

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable Coverage" has the same meaning as provided in the Health Insurance Portability and Accountability Act, P.L.104-191, 110 Stat.1956 Sec.2701(c)(1), and 45 C.F.R. 146.11(a)(1);

(b) "Creditable Coverage" does not include a period of time in which there is a significant break in coverage as described in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1956 Sec. 2701(c)(2).

(3) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

[~~(2)~~] (4) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21.

[~~(3)~~] (5) "Health care provider" has the same meaning as provided in Section 78-14-3.

[~~(4)~~] (6) "Health care services" means any service or product used in furnishing to any individual medical care or hospitalization, or incidental to furnishing medical care or hospitalization, and any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

[~~(5)~~] (7) (a) "Health insurance" means any:

(i) hospital and medical expense-incurred policy;

(ii) nonprofit health care service plan contract; [~~and~~] or

(iii) health maintenance organization subscriber contract.

(b) "Health insurance" does not [~~include~~] mean:

(i) any insurance arising out of the Workers' Compensation Act or similar law[~~,~~];

(ii) automobile medical payment insurance[~~,~~]; or

(iii) insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy.

[~~(6)~~] (8) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

[~~(7)~~] (9) "Health plan" means any arrangement by which [~~a person~~] an individual, including a dependent or spouse, covered or making application to be covered under the pool has

access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract; coverage through a health maintenance organization, preferred provider prepayment, group practice, or individual practice plan; coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance; coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by Medicare or other governmental benefit. The term includes coverage through health insurance.

[~~(8) "Insured" means an individual resident of this state who is eligible to receive benefits from any insurer, health maintenance organization, or other health plan.~~]

(10) "HIPAA" means the Health Insurance Portability and Accountability Act, P.L. 104-91, 110 Stat.1962.

(11) "HIPAA eligible" means an individual who is eligible under ths provisions of the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1979, Sec. 2741(b).

[~~(9)~~] (12) "Insurer" means an insurance company authorized to transact accident and health insurance business in this state, health maintenance organization, and a self-insurer not subject to federal preemption.

[~~(10)~~] (13) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

[~~(11)~~] (14) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

[~~(12)~~] (15) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

[~~(13)~~] (16) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

[~~(14)~~] (17) "Pool Fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

[~~(15)~~] (18) "Pool policy" means [~~an~~] a health insurance policy issued under this chapter.

(19) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the

6-month period immediately prior to the enrollment date.

(20) "Resident" or "residency" means an individual who is domiciled in this state as defined in Section 23-13-2.

[~~(16)~~] (21) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

Section 2. Section **31A-29-104** is amended to read:

31A-29-104. Creation of pool -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Comprehensive Health Insurance Pool," a nonprofit entity within the Insurance Department.

(2) The pool shall be under the direction of a board of directors composed of 11 members.

(a) The governor shall appoint the directors with the consent of the Senate as follows:

(i) two representatives of health insurance companies or health service organizations;

(ii) one representative of a health maintenance organization;

(iii) one physician;

(iv) one representative of hospitals;

(v) one representative of the general public who is reasonably expected to qualify for coverage under the pool;

(vi) one parent or spouse of such an individual;

(vii) one representative of the general public; and

(viii) one representative of employers.

(b) The board shall also include:

(i) the commissioner or his designee; and

(ii) the executive director of the Department of Health or his designee.

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

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

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

(5) (a) (i) Members who are not government employees shall receive no compensation or benefits for their services, but may receive per diem and expenses incurred in the performance of the member's official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107 from the Pool Fund.

(ii) Members may decline to receive per diem and expenses for their service.

(b) (i) State government officer and employee members who do not receive salary, per diem, or expenses from their agency for their service may receive per diem and expenses incurred in the performance of their official duties from the pool at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(ii) A state government member who is a member because of their state government position may not receive per diem or expenses for their service.

(iii) State government officer and employee members may decline to receive per diem and expenses for their service.

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

(7) [~~Seven~~] Six board members are a quorum for the transaction of business.

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

(9) The board shall submit a plan of operation to the commissioner no later than January 1, 1991.

(10) The sale of policies under this chapter shall commence on July 1, 1991, or as soon thereafter as adequate funding for the coverage is available as determined by the commissioner.

Section 3. Section **31A-29-106** is amended to read:

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall have the specific authority to:

[~~(1)~~] (a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

[~~(a)~~] (i) similar pools of other states for the joint performance of common administrative functions; or

[~~(b)~~] (ii) persons or other organizations for the performance of administrative functions;

[~~(2)~~] (b) sue or be sued, including taking such legal action necessary to avoid the payment

of improper claims against the pool or the coverage provided through the pool;

[~~(3)~~] (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

[~~(4)~~] (d) issue policies of insurance in accordance with the requirements of this chapter;

[~~(5)~~] (e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;

[~~(6)~~] (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

[~~(7)~~] (g) cause the pool to have an annual audit of its operations by the state auditor;

[~~(8)~~] (h) coordinate with the Department of Health in seeking to obtain from the [~~United States Health Care Financing Administration~~] Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the [~~insured~~] enrollee;

[~~(9)~~] (i) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

[~~(10)~~] (j) offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;

[~~(11)~~] (k) establish annual limits on benefits payable under the pool to or on behalf of any [~~person~~] enrollee;

[~~(12)~~] (l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

[~~(13)~~] (m) administer the Pool Fund; [~~and~~]

[~~(14)~~] (n) make rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to implement this chapter[~~.~~]; and

(o) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products.

(2) (a) The board shall prepare and submit an annual report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

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

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63, Chapter 38, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

Section 4. Section **31A-29-107** is amended to read:

31A-29-107. Powers of commissioner.

(1) The commissioner shall, after notice and hearing, approve the plan of operation if [~~he~~] the commissioner determines that the plan will assure the fair, reasonable, and equitable administration of the pool.

(2) The plan shall be effective upon the commissioner's written approval.

(3) If the board fails to submit a proposed plan of operation by January 1, 1991, or any time thereafter fails to submit proposed amendments to the plan of operation within a reasonable time after requested by the commissioner, the commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

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

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

[~~(6) (a) The board shall prepare and submit annually to the Legislature a budget forecast for operation of the pool which shall include:~~]

[~~(i) the net premiums anticipated;~~]

[~~(ii) actuarial projections of payments required of the pool;~~]

[~~(iii) the expenses of administration; and~~]

[~~(iv) the anticipated reserves or losses of the pool.~~]

[~~(b) The budget for operation of the pool is subject to the approval of the board.~~]

[~~(c) The administrative budget of the board and the commission under this chapter shall comply with the requirements of Title 63, Chapter 38, Budgetary Procedures Act, and is subject to review and approval by the Legislature.~~]

Section 5. Section **31A-29-109** is amended to read:

31A-29-109. Policy forms -- Ineligibility.

[~~(1)~~] All policy forms issued by the pool shall conform in substance to forms developed by the board and shall be filed with the commissioner before they are issued.

[~~(2) The pool may not issue a pool policy to any person, who on the effective date of the coverage applied for, has coverage substantially equivalent to a pool policy either as an insured or a covered dependent, or who would be eligible for that coverage if he elected to obtain it.~~]

Section 6. Section **31A-29-110** is amended to read:

31A-29-110. Pool administrator -- Selection -- Powers.

(1) The board shall select a pool administrator in accordance with Title 63, Chapter 56, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) ability to manage medical expenses;

(b) proven ability to handle accident and health insurance;

(c) efficiency of claim paying procedures;

(d) marketing and underwriting;

(e) proven ability for managed care and quality assurance;

(f) provider contracting and discounts;

(g) pharmacy benefit management;

[~~(d)~~] (h) an estimate of total charges for administering the pool; and

[~~(e)~~] (i) ability to administer the pool in a cost-efficient manner.

(2) A pool administrator may be:

(a) a health insurer;

(b) a health maintenance organization;

(c) a third-party administrator; or

(d) any person or entity which has demonstrated ability to meet the criteria in Subsection (1).

(3) (a) The pool administrator shall serve for a period of three years subject to removal for cause and subject to the terms, conditions, and limitations of the contract between the board and the administrator.

(b) At least one year prior to the expiration of each three-year period of service by the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator for the succeeding three-year period.

(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of a three-year period of service by the pool administrator.

(4) The pool administrator is responsible for all operational functions of the pool and shall:

(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by statute to be confidential;

(b) perform all marketing, eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;

(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from [~~insured persons~~] enrollees;

(d) perform all necessary functions to assure timely payment of benefits to [~~persons covered under the pool~~] enrollees, including:

(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and

(ii) evaluating the eligibility of each claim for payment by the pool;

(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which reports shall be determined by the board;

(f) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and submit a report of this information to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and

(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Section 7. Section **31A-29-111** is amended to read:

31A-29-111. Eligibility -- Limitations.

(1) (a) Except as provided in Subsection (1)(b), [~~a person~~] an individual is eligible for pool coverage if the individual:

(i) [~~(A) the person~~] pays the established premium; [~~and~~]

[~~(B)~~] (ii) is a resident of this state; [~~or~~] and

(iii) meets the health underwriting criteria under Subsection (4)(a).

[~~(ii) is a dependent child 25 years of age or less of a person described in Subsection (1)(a)(i).~~]

(b) Notwithstanding Subsection (1)(a), [~~a person~~] an individual is not eligible for pool coverage if one of the following conditions apply:

(i) at the time of application, the [~~person~~] individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the [~~person~~] individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the [~~person~~] individual demonstrates that [~~continuous other~~] creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the [~~person~~] individual;

(iv) the [~~person~~] individual is an inmate of a public institution;

(v) the [~~person~~] individual is eligible for other public programs for which medical care is provided;

(vi) the [~~person's~~] individual's health condition does not meet the criteria established under Subsection (4);

(vii) the [~~person~~] individual is an eligible employee, a dependant of an eligible employee, or a member of an employer group that offers health insurance or a self-insurance arrangement to all its eligible employees, dependants, or members; [~~or~~]

(viii) at the time the pool coverage is applied for, the individual has coverage substantially equivalent to a pool policy, as established by the board in administrative rule, either as an insured or a covered dependant, or the individual would be eligible for the substantially equivalent coverage if the individual elected to obtain the coverage; or

[~~(viii)~~] (ix) at the time of application, the [~~person~~] individual:

(A) is not [~~eligible for coverage that is subject to the Health Insurance Portability and Accountability Act, P.L. 104-91, 110 Stat. 1962~~] HIPAA eligible; and

(B) has not resided in Utah for at least 12 consecutive months preceding the date of application.

(2) (a) Notwithstanding Subsection (1)(b)(viii), if otherwise eligible under Subsection (1), [~~a person~~] an individual whose health insurance coverage from a state health risk pool with similar coverage is terminated because of nonresidency in another state may apply for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (vii).

(b) (i) Coverage sought under Subsection (2)(a) shall be applied for within 63 days after the termination date of the previous risk pool coverage.

(ii) If premiums are paid for the entire coverage period under the previous risk pool with similar coverage, the effective date of [~~the pool's~~] this state's pool coverage shall be the date of termination of the previous risk pool coverage.

(iii) If premiums are not paid back to the previous risk pool termination date, then the effective date will be determined by the pool administrator in accordance with the date of application.

(c) The waiting period of [~~a person~~] an individual with a preexisting condition applying for coverage under this chapter shall be waived [~~if~~]:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

(3) If an eligible [~~person~~] individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be [~~set at~~] no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(4) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The [~~commissioner~~] board may contract with one or more providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria under Subsection (4)(a).

(c) If [~~a person~~] an individual is denied coverage by the pool under the criteria established in Subsection (4)(a), the pool shall issue a certificate of insurability to the [~~applicant~~] individual for coverage under Subsection 31A-30-108(3).

Section 8. Section **31A-29-112** is amended to read:

31A-29-112. Medicaid recipients.

(1) If authorized by federal statutes or rules, [~~a person~~] an individual receiving Medicaid benefits may continue to receive those benefits while satisfying the preexisting condition requirements established by Section 31A-29-113 and the terms of the pool policy issued under this chapter.

(2) If allowed by federal statute, federal regulation, state statute, or rule, the Department of Health shall allocate premiums paid to the pool by [~~a person~~] an individual receiving Medicaid benefits to that [~~person's~~] individual's spenddown for purposes of the Medicaid [~~no-grant~~] program.

(3) (a) If [~~a person~~] an individual continues to receive Medicaid benefits after the requirements for a preexisting condition are satisfied, the pool administrator may not issue [~~an insurance~~] a pool policy or allow that [~~person~~] individual to receive any benefit from the pool.

(b) If [~~a person~~] an individual continues to receive Medicaid benefits when the requirements for a preexisting condition are satisfied, the pool administrator shall give any premiums collected by it during the preexisting conditions period to the Medicaid program.

(4) (a) If [~~any person is covered by a pool policy and~~] an enrollee becomes eligible to receive Medicaid benefits, [~~that person's~~] the enrollee's coverage by the pool terminates as of the effective date of [~~the receipt of~~] Medicaid [~~benefits~~] coverage.

(b) The pool administrator shall:

(i) include a provision in the [~~insurance~~] pool policy requiring [~~a person covered by a pool policy~~] an enrollee to provide written notice to the pool administration if [~~he~~] the enrollee becomes covered by Medicaid; and

(ii) terminate [~~a person's~~] an enrollee's coverage by the pool as of the effective date of the [~~person's receipt of~~] enrollee's Medicaid [~~benefits~~] coverage when the pool administrator becomes aware that the [~~person~~] enrollee is covered by Medicaid.

(5) If [~~a person~~] an individual terminates coverage under Medicaid and applies for

coverage under a pool policy within 45 days after terminating the coverage, the [~~person~~] individual may begin coverage under a pool policy as of the date that Medicaid coverage terminated, if [~~a person~~] an individual meets the other eligibility requirements of the chapter and pays the required premium.

(6) [~~If a person's eligibility for Medicaid requires a spenddown, as defined in rule, that exceeds the premium for a pool policy, that person shall be~~] Notwithstanding the provision of Subsection 31A-29-111(1)(b)(i), an individual is eligible for coverage by the pool if the [~~remaining~~] requirements of Section 31A-29-111 are met[~~.~~] and if:

(a) the individual's eligibility for Medicaid requires a spenddown, as defined by rule, that exceeds the premium for a pool policy; or

(b) the individual is eligible for the Primary Care Network program administered by the Department of Health.

Section 9. Section **31A-29-113** is amended to read:

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of [~~health insurance~~] pool policies with different types of benefits which in the opinion of the

board may be of benefit to the citizens of Utah.

(6) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective. The provisions of Sections 31A-22-617 and 31A-22-618 of this title do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded during a six-month period following the effective date of plan coverage [~~as to~~] for a given individual [~~for a preexisting condition, as long as either of the following exists:~~].

[~~(a) the condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinary, prudent person to seek diagnosis or treatment; or~~]

[~~(b) medical advice or treatment was recommended or received for the condition within a period of six months before the effective date of coverage.~~]

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) A pool policy may exclude coverage for pregnancies for ten months following the effective date of coverage, unless the individual is HIPAA eligible [~~to receive credit for previous coverage under the Health Insurance Portability and Accountability Act, P. L. 104-91, 110 Stat. 1962~~].

[~~(9) (a) For individuals changing from individual health insurance, as defined in Subsection 31A-29-103(5), to the health insurance pool, the preexisting condition exclusion described in Subsection (7) shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage:~~]

[~~(i) which was involuntarily terminated, other than for nonpayment of premium, if the application for pool coverage is made not later than 63 days following the involuntary termination; or~~]

[~~(ii) whose premium rate exceeds the rate of the pool for equal or lesser benefits.~~]

[~~(b) If Subsection (9)(a) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.~~]

[~~(10)~~] (9) (a) The pool [~~may not apply any~~] will waive the preexisting condition exclusion [~~to~~] described in Subsection (7)(a) for an individual that is changing [~~group~~] health coverage to the [~~health insurance~~] pool, to the extent to which similar exclusions have been satisfied under any

prior health insurance coverage if:

(i) the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from [~~group~~] health coverage; or

[~~(ii) the individual has at least 18 months of creditable coverage as of the date the individual seeks coverage from:~~]

[~~(A) the health insurance pool; or~~]

[~~(B) an individual health plan;~~]

[~~(iii) the individual's most recent prior creditable coverage was under:~~]

[~~(A) a group health plan;~~]

[~~(B) a government plan; or~~]

[~~(C) a church plan;~~]

[~~(iv) the individual is not eligible for coverage under:~~]

[~~(A) a group health plan;~~]

[~~(B) Part A or Part B of Title XVIII of the Social Security Act; or~~]

[~~(C) a state plan under Title XIX of the Social Security Act;~~]

[~~(v) the individual does not have other health insurance coverage;~~]

[~~(vi) the individual's most recent coverage was not terminated because of:~~]

[~~(A) nonpayment of premiums; or~~]

[~~(B) fraud;~~]

[~~(vii) the individual has been offered the option of continuing coverage under:~~]

[~~(A) a continuation provision; or~~]

[~~(B) a similar state extension program; and~~]

[~~(viii)~~] (ii) the individual's premium rate exceeds the rate of the pool for equal or lesser coverage provided that the application for pool coverage is made no later than 63 days following the termination from the prior health insurance coverage.

(b) In accordance with Subsections (7)(b) and (8), the pool may not apply a preexisting condition exclusion if the individual is HIPAA eligible.

[~~(b)~~] (c) If Subsection [~~(10)(a)~~] (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

[~~(11) The board shall establish a policy allowing for the waiver of the preexisting condition exclusion set forth in Subsection (7) for coverage of medically necessary outpatient~~

~~medical care.~~]

[~~(12) Benefits available under the pool may not exceed $1,000,000 paid to or on behalf of any person.~~]

(10) Covered benefits available from the pool may not exceed a $1,000,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 10. Section **31A-29-114** is amended to read:

31A-29-114. Deductibles -- Copayments.

(1) (a) Subject to the [~~limitation~~] limits provided in Subsection (3), a pool policy shall impose a deductible on a per calendar year basis.

(b) Deductible plans of $500 and $1,000 shall initially be offered. Other deductible plans may be offered by the pool.

(c) The deductible [~~must be~~] is applied to [~~the first $500 or $1,000~~] all of the eligible medical expenses as defined in Section 31A-29-113, incurred by the [~~insured~~] enrollee until the deductible has been satisfied. There are no benefits payable before the deductible has been satisfied.

[~~(d) No more than three deductibles under the pool policy per family may be applied.~~]

(d) The pool may offer separate deductibles for prescription benefits.

(2) (a) Subject to the [~~limitations~~] limits provided in Subsection (3), a mandatory [~~copayment~~] coinsurance requirement shall be imposed at the rate of at least 20% of eligible medical expenses in excess of the mandatory deductible.

(b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool policy.

(3) (a) Except as provided in Subsection (4), the maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the [~~insured~~] enrollee in the form of deductibles and coinsurance may not exceed:

(i) $1,500 per individual [~~or $2,500 per family~~] per [~~policy~~] calendar year for the $500 deductible plan[~~. For the $1,000 deductible plan, the maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance may not exceed $2,000 per individual or $3,000 per family per policy year.~~];

(ii) $2,000 per individual per calendar year for the $1,000 deductible plan; or

(iii) if other deductible plans are offered by the pool, an amount per individual will be

established by the board.

(4) (a) [~~Notwithstanding~~] When the enrollee has incurred the maximum aggregate out-of-pocket payments under Subsection (3), the board may establish a [~~copayment~~] coinsurance requirement to be imposed on eligible medical expenses in excess of the maximum aggregate out-of-pocket expense limits set forth in Subsection (3). [~~Such copayment requirement~~]

(b) The circumstances in which the coinsurance authorized by this Subsection (4) may be imposed shall be designated in the pool policy.

(c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to exceed 5% of eligible medical expenses.

(5) The limits on maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee in the form of deductibles and co-insurance under this section shall not include out-of-pocket payments for prescription benefits.

Section 11. Section **31A-29-115** is amended to read:

31A-29-115. Cancellation --Notice.

(1) (a) On the date of renewal, the pool may cancel [~~a person's~~] an enrollee's policy if:

(i) the [~~person's~~] enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(4);

(ii) the pool has provided written notice to the [~~person's~~] enrollee's last-known address no less than 60 days before cancellation; and

(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.

(b) The pool shall issue a certificate of insurability to [~~a person~~] an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the requirements of Subsection 31A-29-111(4) are met.

(2) The pool may cancel [~~a person's~~] an enrollee's policy at any time if:

[~~(a) the person establishes a residency outside of Utah for three consecutive months; and~~]

[~~(b)~~] (a) the pool has provided written notice to the [~~person's~~] enrollee's last-known address no less than 15 days before cancellation[~~.~~]; and

(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;

(ii) there is non-payment of premiums; or

(iii) the pool determines that the enrollee does not meet the eligibility requirements set

forth in Section 31A-29-111, in which case:

(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;

(B) retroactive termination may not exceed three years; and

(C) the board shall have a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with Subsection 31A-29-119(3).

Section 12. Section **31A-29-117** is amended to read:

31A-29-117. Premium rates.

(1) (a) Premium charges for coverage under the pool may not be unreasonable in relation to:

(i) the benefits provided;

(ii) the risk experience; and

(iii) the reasonable expenses provided in the coverage.

(b) Separate schedules of premium rates based on age and other appropriate demographic characteristics may apply for individual risks.

(2) A small employer carrier, as defined in Section 31A-1-301, shall annually inform the commissioner by April 1 of the carrier's:

(a) small employer index premium rates as of March 1 of the current and preceding year; and

(b) average percentage change in the index premium rate as of March 1, of the current and preceding year.

(3) (a) Premium rates [~~in effect as of January 1, 1997, shall be adjusted on July 1, 1997, and each following July 1 may be adjusted by the board~~] may be adjusted by the board on a bi-annual basis, for an effective date of January 1 and July 1.

(b) In adjusting premium rates, the board shall:

(i) consider the average increase in small employer index rates for the five largest small employer carriers submitted under Subsection (2); and

(ii) be subject to Subsection (1).

(4) The board may establish a premium scale based on income. The highest rate may not exceed the expected claims and expenses for the individual.

(5) If [~~a person~~] an individual is [~~an~~] HIPAA eligible [~~individual as defined in the Health~~

~~Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1979, Sec. 2741(b)~~], the maximum premium rate for that person may not exceed the amount permitted under [~~P.L. 104-191, 110 Stat. 1986, Sec. 2744(c)(2)(B)~~] HIPAA.

(6) All rates and rate schedules shall be submitted by the board to the commissioner for approval.

Section 13. Section **31A-29-119** is amended to read:

31A-29-119. Benefit reduction.

(1) The pool shall be the last payer of benefits whenever any other benefit is available.

(2) Benefits otherwise payable under pool coverage shall be reduced by:

(a) all amounts paid or payable through any other health insurance or any limited health benefit plan, including a self-insured plan;

(b) all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault; and

(c) any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program.

(3) The pool administrator shall have a cause of action against an [~~insured~~] enrollee for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subsection.

Section 14. Section **31A-29-120** is amended to read:

31A-29-120. Enterprise fund.

(1) There is created an enterprise fund known as the Comprehensive Health Insurance Pool Enterprise Fund.

(2) The following funds shall be credited to the Pool Fund:

(a) [~~$5,000,000 appropriated~~] appropriations from the General Fund [~~for Fiscal Year 1997-98~~];

(b) pool policy premium payments; and

(c) all interest and dividends earned on the [~~fund's~~] Pool Fund's assets.

(3) All money received by the Pool Fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter

7, State Money Management Act.

(4) The Pool Fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The Pool Fund shall comply with Title 63A, Utah Administrative Services Code.

Section 15. Section **31A-29-122** is amended to read:

31A-29-122. Immunity.

There is no liability on the part of and no cause of action of any nature may arise against any member of the board, the board's agents or employees, the executive director, the administrator or its agents or employees, or the commissioner for any action or omission by them in effecting the provisions of this chapter.