Part 7
Group Accident and Health Insurance

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

(1) A group insurance policy offering accident and health insurance may be issued to:

(a) a group:

(i) to which a group life insurance policy may be issued under Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-505, 31A-22-506, or 31A-22-507; and

(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;

(b) a group specifically authorized by the commissioner, upon a finding that:

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

(ii) the group is actuarially sound;

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

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

(v) the group would not present hazards of adverse selection;

(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and

(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance; or

(c) a postsecondary educational institution covering students, upon a finding that:

(i) the policy provides standards for financial soundness;

(ii) the policy protects the students covered;

(iii) the policy provides for the establishment of a financially viable alternative to traditional health care plans;

(iv) authorization is not contrary to the public interest;

(v) the policy would not present hazards of adverse selection; and

(vi) the premiums for the policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided.

(2) A blanket insurance policy offering accident and health insurance:

(a) covers a defined class of persons;

(b) may not be offered or underwritten on an individual basis;

(c) shall cover only a group that is:

(i) actuarially sound; and

(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and

(d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;

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

(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;
(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;
(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;
(vii) a newspaper or other publisher, as policyholder, covering its carriers;
(viii) a labor union, as a policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;
(ix) an association that has a constitution and bylaws covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; or
(x) any other class of risks that, in the judgment of the commissioner, may be properly eligible for a blanket insurance policy offering accident and health insurance.

(3) The judgment of the commissioner may be exercised on the basis of:
(a) individual risks;
(b) a class of risks; or
(c) both Subsections(3)(a) and (b).

(4) A group insurance policy offering accident and health insurance issued to a group authorized under Subsection 31A-22-504(1)(b)(ii) is subject to the provisions of Section 31A-22-602.

Amended by Chapter 252, 2021 General Session

31A-22-702 Adjustment of premium rate and application of dividends or rate reductions.

Any group accident and health insurance policy may provide for the adjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any policy of group accident and health insurance, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, including expenditures made in connection with the administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members unless the insured employee or member explicitly elects otherwise.

Amended by Chapter 116, 2001 General Session

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

(1) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance shall include a provision that obligates the policyholder:
(a) to give written notice of termination to each employee or group member 30 days before the day on which the policy terminates; and
(b) to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination.

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

Amended by Chapter 252, 2021 General Session

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

For a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer:
(1) may not refuse to reinstate an insured or the insured's family whose coverage lapsed due to the insured's mobilization into the United States armed forces provided application is made within 180 days after the day on which the insured is released from active duty;
(2) shall reinstate an insured in full upon payment of the first premium without the requirement of a waiting period or exclusion for preexisting conditions or any other underwriting requirements that were covered previously; and
(3) may not increase the insured's premium in excess of what the premium would have been increased to in the normal course of time had the insured not been mobilized into the United States armed forces.

Amended by Chapter 252, 2021 General Session

31A-22-719 Mastectomy coverage.
(1) A group policy subject to Section 31A-22-630 may not deny a person's eligibility or continued eligibility to enroll or renew coverage under the terms of the group policy plan solely for the purpose of avoiding the requirements of this section or Section 31A-22-630.
(2) A group policy subject to Section 31A-22-630 may not do any of the following to induce a provider to provide care to an insured in a manner inconsistent with this section or Section 31A-22-630:
(a) penalize or otherwise reduce or limit the reimbursement of an attending provider; or
(b) provide incentives to an attending provider whether or not the incentives are monetary.

Enacted by Chapter 114, 2000 General Session

31A-22-722 Utah mini-COBRA benefits for employer group coverage.
(1) An employer's group policy shall offer an employee's coverage to be extended under the current employer's group policy for a period of 12 months, except as provided in Subsection (2). The right to extend coverage includes:
(a) voluntary termination;
(b) involuntary termination;
(c) retirement;
(d) death;
(e) divorce or legal separation;
(f) loss of dependent status;
(g) sabbatical;
(h) a disability;
(i) leave of absence; or

(j) reduction of hours.

(2)

(a) Notwithstanding Subsection (1), an employee may not extend coverage under the current employer's group insurance policy if the employee:

(i) fails to pay premiums or contributions in accordance with the terms of the insurance policy;

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

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

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

(v) is terminated from employment for gross misconduct;

(vi) is not continuously covered under the current employer's group policy for a period of three months immediately before the termination of the insurance policy due to an event set forth in Subsection (1);

(vii) is eligible for an extension of coverage required by federal law;

(viii) establishes residence outside of this state;

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

(x) is eligible for similar coverage under another group insurance policy; or

(xi) has the employee's coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

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

(3)

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

(i) a terminated insured;

(ii) an ex-spouse of an insured; or

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

(A) a surviving spouse; and

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

(b) The notification required in Subsection (3)(a) shall be sent first class mail within 30 days after the termination date of the group coverage to:

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

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

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

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

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

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

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

(5)

(a) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.
(b) Except as provided in Subsection (5)(a), an insurer may not charge an insured an additional fee, an additional premium, interest, or any similar charge for electing extended group coverage.
(6) Except as provided in this Subsection (6), coverage extends without interruption for 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:
(a) elects to extend group coverage within 60 days of losing group coverage; and
(b) tenders the amount required to the employer or insurer.
(7) The insured's coverage may be terminated before 12 months if the terminated insured:
(a) establishes residence outside of this state;
(b) moves out of the insurer's service area;
(c) fails to pay premiums or contributions in accordance with the terms of the insurance policy, including any timeliness requirements;
(d) performs an act or practice that constitutes fraud in connection with the coverage;
(e) makes an intentional misrepresentation of material fact under the terms of the coverage;
(f) becomes eligible for similar coverage under another group insurance policy; or
(g) has the coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).
(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group insurance policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:
(a) for the balance of the period the terminated insured would have extended coverage under the replaced group insurance policy; and
(b) if the terminated insured is otherwise eligible for extension of coverage.
(9) An insurer shall require an insured employer to offer to the following individuals an open enrollment period at the same time as other regular employees:
(a) an individual who extends group coverage and is current on payment; and
(b) during the applicable grace period described in Subsection (3) or (4), an individual who is eligible to elect to extend group coverage.

Amended by Chapter 193, 2019 General Session

31A-22-725 Special enrollment periods relating to Medicaid and Children's Health Insurance Program.

(1) A person is eligible to enroll for coverage under the terms of an employer's group health benefit plan if:
(a) the person is:
(i) an employee who is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; or
(ii) a dependent of an employee, if the dependent is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; and
(b) the conditions of either Subsection (2) or (3) are met.
(2) Subsection (1) applies if:
(a) the employee or dependent is covered under:

(i) a Medicaid health benefit plan under Title XIX of the Social Security Act; or
(ii) a state child health benefit plan under Title XXI of the Social Security Act;
(b) coverage of the employee or dependent described in Subsection (2)(a) is terminated as a result of loss of eligibility for the coverage; and
(c) the employee requests coverage under the employer's group health plan no later than 60 days after the date of termination of the coverage described in Subsection (2)(a).
(3) Subsection (1) applies if:
(a) the employee or dependent becomes eligible for assistance, with respect to coverage under the employer's group health plan under a plan described in Subsection (2)(a), including under a waiver or demonstration project conducted under or in relation to a plan described in Subsection (2)(a); and
(b) the employee requests coverage under the employer's group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for the assistance described in Subsection (3)(a).

Enacted by Chapter 10, 2010 General Session

31A-22-726 Abortion coverage restriction in health benefit plan and on health insurance exchange.

(1) As used in this section, "permitted abortion coverage" means coverage for abortion:
(a) that is necessary to avert:
(i) the death of the woman on whom the abortion is performed; or
(ii) a serious risk of substantial and irreversible impairment of a major bodily function of the woman on whom the abortion is performed;
(b) of a fetus that has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal; or
(c) where the woman is pregnant as a result of:
(i) rape, as described in Section 76-5-402;
(ii) rape of a child, as described in Section 76-5-402.1; or
(iii) incest, as described in Subsection 76-5-406(2)(j) or Section 76-7-102.
(2) A person may not offer coverage for an abortion in a health benefit plan, unless the coverage is a type of permitted abortion coverage.
(3) A person may not offer a health benefit plan that provides coverage for an abortion in a health insurance exchange created under the federal Patient Protection and Affordable Care Act, 111 P.L. 148, unless the coverage is a type of permitted abortion coverage.

Amended by Chapter 189, 2019 General Session
Amended by Chapter 193, 2019 General Session

31A-22-727 Renewal, cancellation, and modification.

(1) Except as provided in Section 31A-22-618.6, for a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer may:
(a) decline to renew the policy on the date the policy term expires for a reason stated in the policy; or
(b) cancel the policy at any time for:
(i) nonpayment of a premium when due;
(ii) intentional misrepresentation of a material fact in connection with the coverage;

(iii) performance of an act or practice that constitutes fraud in connection with the coverage; or
(iv) noncompliance with an employer eligibility provision.
(2) Except for a modification required by law, an insurer may only modify a policy at renewal.
(3) Subsection (2) does not apply to an endorsement by which the insurer:
(a) effectuates a request the policyholder made in writing; or
(b) exercises a specifically reserved right under the policy.

Enacted by Chapter 198, 2022 General Session

31A-22-728 Large employer health benefit plan required report.
(1) As used in this section:
(a) "Claims run-out period" means the period beginning on the first day following the last day of a plan year and ending on the 90th day following the last day of a plan year.
(b) "Large employer" means an employer who:
(i) with respect to a calendar year and to a plan year:
(A) employed an average of at least 51 employees on a business day during the preceding calendar year; and
(B) employs at least one employee on the first day of the plan year; and
(ii) has at least 51 but fewer than 100 enrolled eligible employees enrolled in a group health benefit plan during each consecutive month during the plan year.
(c) "Medical loss ratio" means a group health benefit plan's paid claims incurred during a plan year, including the claims run-out period, divided by the total premium revenue collected for the plan year.
(2) Except as provided in Subsection (6), beginning on January 1, 2024, an insurer that offers a large employer health benefit plan to a large employer shall annually provide a report, upon request of:
(a) the large employer;
(b) the large employer's appointed producer; or
(c) the large employer's consultant.
(3) The report described in Subsection (2) shall include:
(a) after the first renewal, the health benefit plan's aggregate performance from the immediately preceding plan year that describes whether the health benefit plan had a medical loss ratio of:
(i) less than 85%;
(ii) between 85% and 125%; or
(iii) greater than 125%; and
(b) after the second renewal and each subsequent renewal thereafter, a summary of the health benefit plan's aggregate 24-month medical loss ratio from the immediately preceding two plan years combined.
(4) An insurer that offers a large employer health benefit plan shall provide the requested report described in Subsection (2) not less than 30 days after the claims run-out period.
(5)
(a) The report described in Subsection (2) is proprietary to the large employer, the large employer's appointed producer, or the large employer's consultant.
(b) A person may not share the report described in Subsection (2) with a party other than a party described in Subsection (5)(a).
(6) An insurer is not required to provide a report as described in this section if:
(a) the health benefit plan is a qualified health plan as defined in 45 C.F.R. Sec. 155.20;

(b) the health benefit plan is issued to a group other than an employee group described in Section 31A-22-502;
(c) the large employer has not had continuous large employer health benefit plan coverage with the insurer for at least 18 months before the date on which the large employer requests the report;
(d) the large employer does not renew coverage with the insurer; or
(e) the insurer reasonably believes that providing the report would disclose information described in Subsection 13-61-102(2)(g).

(7) An insurer that provides a report in compliance with this section is immune from civil liability for the insurer's acts or omissions in providing information required under Subsection (3).

Enacted by Chapter 194, 2023 General Session