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H.B. 254
1st Sub. (Buff)

Representative Rebecca D. Lockhart proposes to substitute the following bill:

INSURANCE DEPARTMENT - HEALTH INSURANCE REPORTING REQUIREMENTS

2000 GENERAL SESSION

STATE OF UTAH

Sponsor: Rebecca D. Lockhart

AN ACT RELATING TO INSURANCE; AMENDING OR ELIMINATING CERTAIN REPORTING REQUIREMENTS OF THE DEPARTMENT; ELIMINATING THE REQUIREMENT THAT THE DEPARTMENT DEVELOP A BASIC INDIVIDUAL HEALTH CARE PLAN; AND MAKING TECHNICAL AND CONFORMING AMENDMENTS.

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

AMENDS:

31A-22-613.5, as last amended by Chapter 13, Laws of Utah 1998

31A-30-103, as last amended by Chapter 265, Laws of Utah 1997

31A-30-110, as last amended by Chapters 10 and 265, Laws of Utah 1997

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

Section 1. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance.

(1) This section applies generally to all health insurance policies and health maintenance organization contracts.

(2) (a) Immediately after the effective date of this section, the commissioner shall appoint a Health Benefit Plan Committee.

(b) The committee shall be composed of representatives of carriers, employers, employees, health care providers, consumers, and producers, appointed to four-year terms.

(c) Notwithstanding the requirements of Subsection (2)(b), the commissioner shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of

committee members are staggered so that approximately half of the committee is appointed every two years.

(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(4) (a) Members 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.

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

[~~(5) The committee shall serve as an advisory committee to the commissioner and shall recommend services to be covered, copays, deductibles, levels of coinsurance, annual out-of-pocket maximums, exclusions, and limitations for two or more designated health care plans to be marketed in the state.~~]

[~~(a) The plans recommended by the committee may include reasonable benefit differentials applicable to participating and nonparticipating providers.~~]

[~~(b) The plans recommended by the committee shall not prohibit the use of the following cost management techniques by an insurer:~~]

[~~(i) preauthorization of health care services;~~]

[~~(ii) concurrent review of health care services;~~]

[~~(iii) case management of health care services;~~]

[~~(iv) retrospective review of medical appropriateness;~~]

[~~(v) selective contracting with hospitals, physicians, and other health care providers to the extent permitted by law; and~~]

[~~(vi) other reasonable techniques intended to manage health care costs.~~]

[~~(c) The committee shall submit the plans to the commissioner within 180 days after the appointment of the committee in accordance with this section.~~]

[~~(d) The commissioner shall adopt two or more health benefit plans within 60 days after the committee submits recommendations.~~]

[~~(e) If the committee fails to submit recommendations to the commissioner within 180 days after appointment, the commissioner shall, within 90 days, develop two or more designated health benefit plans. The commissioner shall, after notice and hearing, adopt two or more designated health benefit plans. The commissioner shall provide incentives for personal~~

~~management of health care expenses by adopting one plan that applies deductibles in the amount of $1,500 and another plan that applies deductibles in the amount of $2,500. These plans may include illustrations and explanations showing the premium savings generated by the high deductibles being applied to a medical savings account for the insured which can be used to pay medical expenses up to the plan deductible and/or any other medical expenses not covered by the insurance, and an explanation that any funds in the savings account belong to the insured.~~]

[~~(f) The commissioner may reconvene a Health Benefit Plan Committee in accordance with Subsections (2) and (5) to recommend revisions to the designated benefit plans adopted by the commissioner.~~]

[~~(6) (a) Within 180 days after the adoption of the designated benefit plans by the commissioner, or any changes in the designated plans an insurer offering health insurance policies for sale in this state shall, at the request of a potential buyer, offer the current designated plans at a premium based on factors such as that buyer's previous claims experience, group size, demographic characteristics, and health status.~~]

[~~(b) This section does not prohibit an insurer from refusing to insure, under any plan, a person or group. However, if the insurer offers any policy or contract to that person or group, the insurer must offer the designated plans.~~]

[~~(7) The designated benefit plans, described in Subsection (5) are intended to facilitate price and value comparisons by consumers. The designated benefit plans are not minimum standards for health insurance policies. An insurer offering the designated benefit plans may offer policies that provide more or less coverage than the designated benefit plans.~~]

[~~(8)~~] (5) (a) The commissioner shall convene or reconvene a Health Benefit Plan Committee for the purpose of developing a Basic Health Care Plan to be offered under the open enrollment provisions of Chapter 30.

(b) The commissioner shall adopt a Basic Health Care Plan within 60 days after the committee submits recommendations, or if the committee fails to submit recommendations to the commissioner within 180 days after appointment, the commissioner shall, within 90 days, adopt a Basic Health Care Plan.

[~~(c) (i) Before adoption of a plan under Subsection (8)(b), the commissioner shall submit the proposed Basic Health Care Plan to the Health and Human Services Interim Committee for review and recommendations.~~]

[~~(ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human Services Interim Committee shall provide legislative oversight of the Basic Health Care Plan and may recommend legislation to modify the Basic Health Care Plan adopted by the commissioner.~~]

[~~(d)~~] (c) The committee's recommendations for the Basic Health Care Plan shall be advisory to the commissioner.

[~~(9) (a)~~] (6) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer issuing health insurance policies or health maintenance organization contracts to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, written disclosure of:

(i) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution. If a formulary is used, the drugs included and the patented drugs not included, and any conditions which exist as a precedent to coverage shall be made readily available to prospective enrollees and evidence of the fact of that disclosure shall be maintained by the insurer; and

(ii) coverage limits under the plan.

[~~(b) An insurer described in Subsection (9)(a) shall also submit the written disclosure required by this Subsection to the commissioner annually, and anytime thereafter when the insurer amends the treatment policies, practice standards, or restrictions described in Subsection (8)(a).~~]

[~~(c)~~] (b) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (6), taking into account business confidentiality of the insurer, definitions of terms, and the method of disclosure to enrollees.

[~~(10) (a) The commissioner shall annually publish a table comparing the rates charged by insurers for the designated health plans and other health insurance plans in this state.~~]

[~~(b) The comparison shall list the top 20 insurers writing the greatest volume by premium dollar per calendar year and others requesting inclusion in the comparison.~~]

[~~(c) In conjunction with the rate comparison described in this subsection, the commissioner shall publish for each of the listed health insurers a table comparing the complaints filed and the combined loss and expense ratio as described in Subsections 31A-2-208.5(2) and (3).~~]

Section 2. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this part:

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

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

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

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan established by the Health Benefit Plan Committee under [~~Subsection~~] Section 31A-22-613.5[~~(8)~~].

(5) "Carrier" means any person or entity that provides health insurance in this state including an insurance company, a prepaid hospital or medical care plan, a health maintenance organization, a multiple employer welfare arrangement, and any other person or entity providing a health insurance plan under this title.

(6) "Case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured. However, duration of coverage since the policy was issued, claim experience, and health status, are not case characteristics for the purposes of this chapter.

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

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Title 31A, Chapter 22, Part VII, Group Disability Insurance.

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

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

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

(12) "Dependent" means individuals to the extent they are defined to be a dependent by:

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

(b) the provisions of Chapter 22, Part VI, Disability Insurance.

(13) (a) "Eligible employee" means:

(i) an employee who works on a full-time basis and has a normal work week of 30 or more hours, and includes a sole proprietor, and a partner of a partnership, if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer; or

(ii) an independent contractor if the independent contractor is included under a health benefit plan of a small employer.

(b) "Eligible employee" does not include:

(i) an employee who works on a part-time, temporary, or substitute basis; or

(ii) the spouse or dependents of the employer.

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

(15) "Health benefit plan" means any certificate under a group health insurance policy, or any health insurance policy, except that health benefit plan does not include coverage only for:

(a) accident;

(b) dental;

(c) vision;

(d) Medicare supplement;

(e) long-term care; or

(f) the following when offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance:

(i) specified disease;

(ii) hospital confinement indemnity; or

(iii) limited benefit plan.

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

(17) "Individual carrier" means a carrier that offers health benefit plans covering insureds in this state under individual policies.

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

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

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

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

(22) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier. However, a covered carrier may not have more than one rating period in any calendar month, and no more than 12 rating periods in any calendar year.

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

(24) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed at least two and no more than 50 eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(25) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

(26) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(4); or

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

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

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

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

(b) "CI" means the carrier's individual coverage count as of December 31 of the preceding year.

Section 3. Section **31A-30-110** is amended to read:

31A-30-110. Individual enrollment cap.

(1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.

(2) The commissioner shall raise the individual enrollment cap by .5% at the later of the following dates:

(a) six months from the last increase in the individual enrollment cap; or

(b) the date when CCI/TI is greater than .90, where:

(i) "CCI" is the total individual coverage count for all carriers certifying that their uninsurable percentage has reached the individual enrollment cap; and

(ii) "TI" is the total individual coverage count for all carriers.

(3) The commissioner may establish a minimum number of uninsurable individuals that a carrier entering the market who is subject to this chapter must accept under the individual enrollment provisions of this chapter.

(4) Beginning July 1, 1997, an individual carrier may decline to accept individuals applying for individual enrollment under Subsection 31A-30-108(3), other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:

(a) the uninsurable percentage for that carrier equals or exceeds the cap established in Subsection (1); and

(b) the covered carrier has certified on forms provided by the commissioner that its uninsurable percentage equals or exceeds the individual enrollment cap.

(5) The department may audit a carrier's records to verify whether the carrier's uninsurable classification meets industry standards for underwriting criteria as established by the commissioner

in accordance with Subsection 31A-30-106(1)(k).

(6) (a) On or before July 1, 1997, and each July 1 thereafter, the commissioner:

(i) shall report to the [~~Utah Health Policy Commission on~~] Health and Human Services Interim Committee, upon request of the committee, regarding the distribution of risks assumed by various carriers in the state under the individual enrollment provision of this part; and

(ii) may [~~make~~] offer recommendations to the [~~Utah Health Policy Commission and the Legislature~~] Health and Human Services Interim Committee regarding the adjustment of the .5% cap on individual enrollment or some other risk adjustment to maintain equitable distribution of risk among carriers.

(b) If the commissioner determines that individual enrollment is causing a substantial adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or delay further individual enrollment for up to 12 months.

(c) The commissioner shall adopt rules to establish a uniform methodology for calculating and reporting loss ratios for individual policies for determining whether the individual enrollment provisions of Section 31A-30-108 should be waived for an individual carrier experiencing significant and adverse financial impact as a result of complying with those provisions.

[~~(7) (a) On or before November 30, 1995, the commissioner shall report to the Health Policy Commission and the Legislature on:~~]

[~~(i) the impact of the Small Employer Health Insurance Act on availability of small employer insurance in the market;~~]

[~~(ii) the number of carriers who have withdrawn from the market or ceased to issue new policies since the implementation of the Small Employer Health Insurance Act;~~]

[~~(iii) the expected impact of the individual enrollment provisions on the factors described in Subsections (7)(i) and (ii); and~~]

[~~(iv) the claims experience, costs, premiums, participation, and viability of the Comprehensive Health Insurance Pool created in Chapter 29.~~]

[~~(b) The report to the Legislature shall be submitted in writing to each legislator.~~]