REPEAL OF HEALTH BENEFIT PLAN COMMITTEE

2002 GENERAL SESSION

STATE OF UTAH

Sponsor: Don E. Bush

This act modifies the Insurance Code by repealing the Health Benefit Plan Committee.

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

AMENDS:

31A-22-613.5, as last amended by Chapter 116, Laws of Utah 2001

31A-30-103, as last amended by Chapter 116, Laws of Utah 2001

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.~~]

[~~(c) A member of the committee shall be appointed to a four-year term.~~]

[~~(d) Notwithstanding the requirements of Subsection (2)(c), 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.~~]

[~~(6)~~] (2) (a) The commissioner shall [~~convene or reconvene a Health Benefit Plan Committee for the purpose of developing~~] adopt 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)~~] (b) (i) Before adoption of a plan under Subsection [~~(6)(b)~~] (2)(a), 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:

(A) shall provide legislative oversight of the Basic Health Care Plan; and

(B) may recommend legislation to modify the Basic Health Care Plan adopted by the commissioner.

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

[~~(7)~~] (3) (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; and

(ii) coverage limits under the plan.

(b) In addition to the requirements of Subsections [~~(7)~~] (3)(a) and (d), an insurer described in Subsection [~~(7)~~] (3)(a) shall submit the written disclosure required by this Subsection [~~(7)~~] (3) to

the commissioner:

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

(ii) anytime the insurer amends any of the following described in Subsection [~~(7)~~] (3)(a):

(A) treatment policies;

(B) practice standards;

(C) restrictions; or

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

(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection [~~(7)~~] (3), taking into account:

(i) business confidentiality of the insurer;

(ii) definitions of terms; and

(iii) the method of disclosure to enrollees.

(d) If under Subsection [~~(7)~~] (3)(a)(i) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included; and

(iii) any conditions that exist as a precedent to coverage.

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 31A-22-613.5[~~(6)~~] (2).

(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 Accident and Health 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~~] Accident and Health 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 conversion policy" means a conversion policy issued by a health benefit

plan as defined in Subsection (15) to:

(a) an individual; or

(b) an individual with a family.

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

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

(21) "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.

(22) "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.

(23) "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.

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

(25) "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.

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

(27) "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(1)(k) and (l) for which coverage the applicant is applying.

(28) "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.