

**HEALTH INSURANCE ACT AMENDMENTS**

2004 GENERAL SESSION

STATE OF UTAH

**Sponsor: James A. Dunnigan**

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**LONG TITLE**

**General Description:**

This bill amends accident and health insurance provisions related to premium grace periods, ~~§ [conversion policy rating restrictions,]~~ ~~§~~ and discontinuation of coverage in the individual and small employer market.

**Highlighted Provisions:**

This bill:

- ▶ changes the grace period for nonpayment of premium to 15 days;
- ▶ clarifies coverage during a grace period;
- ▶ provides that if the Comprehensive Health Insurance Pool is dissolved or discontinued, or if enrollment is capped or suspended, a covered carrier:
  - may elect to discontinue offering new individual health benefit plans but then may not reenter the individual market for five years;
  - may continue to write business in the small employer market; and
  - may decline to accept individuals applying for individual enrollment, other than HIPAA eligible individuals;
- ▶ repeals the provision that links individual premium rates to the rates established by the Comprehensive Health Insurance Pool;
- ▶ amends preexisting conditions waiver provisions for the Comprehensive Health Insurance Pool; ~~§ [and]~~
- ▶ **AMENDS POWERS OF THE BOARD; AND §**
- ▶ makes technical amendments.

**Monies Appropriated in this Bill:**



28 None

29 **Other Special Clauses:**

30 § [~~None~~] **THIS BILL PROVIDES AN IMMEDIATE EFFECTIVE DATE.** §

31 **Utah Code Sections Affected:**

32 AMENDS:

33 **31A-8-402.3**, as last amended by Chapter 252, Laws of Utah 2003

34 **31A-22-607**, as last amended by Chapter 116, Laws of Utah 2001

35 **31A-22-721**, as last amended by Chapter 252, Laws of Utah 2003

35a § **31A-29-106, AS LAST AMENDED BY CHAPTER 168, LAWS OF UTAH 2003** §

36 **31A-29-113**, as last amended by Chapter 168, Laws of Utah 2003

37 **31A-30-107**, as last amended by Chapter 252, Laws of Utah 2003

38 **31A-30-107.3**, as enacted by Chapter 308, Laws of Utah 2002

39 **31A-30-108**, as last amended by Chapter 308, Laws of Utah 2002

40 REPEALS:

41 **31A-30-106.6**, as enacted by Chapter 265, Laws of Utah 1997



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

44 Section 1. Section **31A-8-402.3** is amended to read:

45 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**  
46 **plans.**

47 (1) Except as otherwise provided in this section, a group health benefit plan for a plan  
48 sponsor is renewable and continues in force:

49 (a) with respect to all eligible employees and dependents; and

50 (b) at the option of the plan sponsor.

51 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

52 (a) for a network plan, if:

53 (i) there is no longer any enrollee under the group health plan who lives, resides, or

54 works in:

55 (A) the service area of the insurer; or

56 (B) the area for which the insurer is authorized to do business; and

57 (ii) in the case of the small employer market, the insurer applies the same criteria the

58 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108[~~(6)~~] (7);

59 or

60 (b) for coverage made available in the small or large employer market only through an  
61 association, if:

62 (i) the employer's membership in the association ceases; and

63 (ii) the coverage is terminated uniformly without regard to any health status-related  
64 factor relating to any covered individual.

65 (3) A health benefit plan for a plan sponsor may be discontinued if:

66 (a) a condition described in Subsection (2) exists;

67 (b) the plan sponsor fails to pay premiums or contributions in accordance with the  
68 terms of the contract;

69 (c) the plan sponsor:

70 (i) performs an act or practice that constitutes fraud; or

71 (ii) makes an intentional misrepresentation of material fact under the terms of the  
72 coverage;

73 (d) the insurer:

74 (i) elects to discontinue offering a particular health benefit product delivered or issued  
75 for delivery in this state; and

76 (ii) (A) provides notice of the discontinuation in writing:

77 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

78 (II) at least 90 days before the date the coverage will be discontinued;

79 (B) provides notice of the discontinuation in writing:

80 (I) to the commissioner; and

81 (II) at least three working days prior to the date the notice is sent to the affected plan  
82 sponsors, employees, and dependents of the plan sponsors or employees;

83 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:

84 (I) all other health benefit products currently being offered by the insurer in the market;

85 or

86 (II) in the case of a large employer, any other health benefit product currently being  
87 offered in that market; and

88 (D) in exercising the option to discontinue that product and in offering the option of  
89 coverage in this section, acts uniformly without regard to:

- 90 (I) the claims experience of a plan sponsor;
- 91 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 92 (III) any health status-related factor relating to any new participant or beneficiary who
- 93 may become eligible for the coverage; or
- 94 (e) the insurer:
  - 95 (i) elects to discontinue all of the insurer's health benefit plans in:
    - 96 (A) the small employer market;
    - 97 (B) the large employer market; or
    - 98 (C) both the small employer and large employer markets; and
  - 99 (ii) (A) provides notice of the discontinuation in writing:
    - 100 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
    - 101 (II) at least 180 days before the date the coverage will be discontinued;
  - 102 (B) provides notice of the discontinuation in writing:
    - 103 (I) to the commissioner in each state in which an affected insured individual is known
    - 104 to reside; and
    - 105 (II) at least 30 working days prior to the date the notice is sent to the affected plan
    - 106 sponsors, employees, and the dependents of the plan sponsors or employees;
    - 107 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
    - 108 market; and
    - 109 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- 110 (4) A large employer health benefit plan may be discontinued or nonrenewed:
  - 111 (a) if a condition described in Subsection (2) exists; or
  - 112 (b) for noncompliance with the insurer's:
    - 113 (i) minimum participation requirements; or
    - 114 (ii) employer contribution requirements.
- 115 (5) A small employer health benefit plan may be discontinued or nonrenewed:
  - 116 (a) if a condition described in Subsection (2) exists; or
  - 117 (b) for noncompliance with the insurer's employer contribution requirements.
- 118 (6) A small employer health benefit plan may be nonrenewed:
  - 119 (a) if a condition described in Subsection (2) exists; or
  - 120 (b) for noncompliance with the insurer's minimum participation requirements.

121 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be  
 122 discontinued if after issuance of coverage the eligible employee:

123 (i) engages in an act or practice in connection with the coverage that constitutes fraud;

124 or

125 (ii) makes an intentional misrepresentation of material fact in connection with the  
 126 coverage.

127 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

128 (i) 12 months after the date of discontinuance; and

129 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
 130 to reenroll.

131 (c) At the time the eligible employee's coverage is discontinued under Subsection  
 132 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is  
 133 discontinued.

134 (d) An eligible employee may not be discontinued under this Subsection (7) because of  
 135 a fraud or misrepresentation that relates to health status.

136 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to  
 137 the employer:

138 (a) with respect to coverage provided to an employer member of the association; and

139 (b) if the health benefit plan is made available by an insurer in the employer market  
 140 only through:

141 (i) an association;

142 (ii) a trust; or

143 (iii) a discretionary group.

144 (9) An insurer may modify a health benefit plan for a plan sponsor only:

145 (a) at the time of coverage renewal; and

146 (b) if the modification is effective uniformly among all plans with that product.

147 Section 2. Section **31A-22-607** is amended to read:

148 **31A-22-607. Grace period.**

149 (1) Every individual or franchise accident and health insurance policy shall contain  
 150 clauses providing for a grace period for premium payment only of at least [~~seven days for~~  
 151 ~~weekly premium policies, ten~~] 15 days ~~h~~ [f] ~~for~~ ~~h~~ WEEKLY OR h ~~monthly premium policies and~~  
 151a **30 days for all other** [f] ~~h~~

152 ~~It~~ [F] policies, for each premium after the first [F] h . ~~[During the grace period, the policy~~  
 152a continues in  
 153 force]. A carrier may elect to include a grace period that is longer than 15 days ~~It~~ **FOR WEEKLY OR**  
 153a **MONTHLY POLICIES** h .

154 (a) The policy is not in force during the grace period.

155 (b) If the insurer receives payment before the grace period expires, the policy continues  
 156 in force with no gap in coverage.

157 (c) If the insurer does not receive payment before the grace period expires, the policy  
 158 shall be terminated as of the last date for which the premium was paid in full.

159 (d) A grace period is not required if the policyholder has requested that the policy be  
 160 discontinued.

161 (2) Every group or blanket accident and health policy shall provide for a grace period  
 162 of at least 30 days, unless the policyholder gives written notice of discontinuance prior to the  
 163 date of discontinuance, in accordance with the policy terms. In group or blanket policies, the  
 164 policy may provide for payment of a pro rata premium for the period the policy is in effect  
 165 during the grace period under this Subsection (2).

166 (3) If the insurer has not guaranteed the insured a right to renew an accident and health  
 167 policy, any grace period beyond the expiration or anniversary date may, if provided in the  
 168 policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

169 Section 3. Section **31A-22-721** is amended to read:

170 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**  
 171 **nonrenewal.**

172 (1) Except as otherwise provided in this section, a health benefit plan for a plan  
 173 sponsor is renewable and continues in force:

174 (a) with respect to all eligible employees and dependents; and

175 (b) at the option of the plan sponsor.

176 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

177 (a) for a network plan, if:

178 (i) there is no longer any enrollee under the group health plan who lives, resides, or  
 179 works in:

180 (A) the service area of the insurer; or

181 (B) the area for which the insurer is authorized to do business; and

182 (ii) in the case of the small employer market, the insurer applies the same criteria the

183 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108[(6)] (7);  
184 or

185 (b) for coverage made available in the small or large employer market only through an  
186 association, if:

187 (i) the employer's membership in the association ceases; and

188 (ii) the coverage is terminated uniformly without regard to any health status-related  
189 factor relating to any covered individual.

190 (3) A health benefit plan for a plan sponsor may be discontinued if:

191 (a) a condition described in Subsection (2) exists;

192 (b) the plan sponsor fails to pay premiums or contributions in accordance with the  
193 terms of the contract;

194 (c) the plan sponsor:

195 (i) performs an act or practice that constitutes fraud; or

196 (ii) makes an intentional misrepresentation of material fact under the terms of the  
197 coverage;

198 (d) the insurer:

199 (i) elects to discontinue offering a particular health benefit product delivered or issued  
200 for delivery in this state;

201 (ii) (A) provides notice of the discontinuation in writing:

202 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and

203 (II) at least 90 days before the date the coverage will be discontinued;

204 (B) provides notice of the discontinuation in writing:

205 (I) to the commissioner; and

206 (II) at least three working days prior to the date the notice is sent to the affected plan  
207 sponsors, employees, and dependents of plan sponsors or employees;

208 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any  
209 other health benefit products currently being offered:

210 (I) by the insurer in the market; or

211 (II) in the case of a large employer, any other health benefit plan currently being  
212 offered in that market; and

213 (D) in exercising the option to discontinue that product and in offering the option of

214 coverage in this section, the insurer acts uniformly without regard to:

215 (I) the claims experience of a plan sponsor;

216 (II) any health status-related factor relating to any covered participant or beneficiary; or

217 (III) any health status-related factor relating to a new participant or beneficiary who

218 may become eligible for coverage; or

219 (e) the insurer:

220 (i) elects to discontinue all of the insurer's health benefit plans:

221 (A) in the small employer market; or

222 (B) the large employer market; or

223 (C) both the small and large employer markets;

224 (ii) (A) provides notice of the discontinuance in writing:

225 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

226 (II) at least 180 days before the date the coverage will be discontinued;

227 (B) provides notice of the discontinuation in writing:

228 (I) to the commissioner in each state in which an affected insured individual is known

229 to reside; and

230 (II) at least 30 business days prior to the date the notice is sent to the affected plan

231 sponsors, employees, and dependents of a plan sponsor or employee;

232 (C) discontinues and nonrenews all plans issued or delivered for issuance in the

233 market; and

234 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

235 (4) A large employer health benefit plan may be discontinued or nonrenewed:

236 (a) if a condition described in Subsection (2) exists; or

237 (b) for noncompliance with the insurer's:

238 (i) minimum participation requirements; or

239 (ii) employer contribution requirements.

240 (5) A small employer health benefit plan may be discontinued or nonrenewed:

241 (a) if a condition described in Subsection (2) exists; or

242 (b) for noncompliance with the insurer's employer contribution requirements.

243 (6) A small employer health benefit plan may be nonrenewed:

244 (a) if a condition described in Subsection (2) exists; or



245 (b) for noncompliance with the insurer's minimum participation requirements.  
246 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be  
247 discontinued if after issuance of coverage the eligible employee:  
248 (i) engages in an act or practice that constitutes fraud in connection with the coverage;  
249 or  
250 (ii) makes an intentional misrepresentation of material fact in connection with the  
251 coverage.  
252 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:  
253 (i) 12 months after the date of discontinuance; and  
254 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
255 to reenroll.  
256 (c) At the time the eligible employee's coverage is discontinued under Subsection  
257 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is  
258 discontinued.  
259 (d) An eligible employee may not be discontinued under this Subsection (7) because of  
260 a fraud or misrepresentation that relates to health status.  
261 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue  
262 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new  
263 business in such market in this state for a period of five years beginning on the date of  
264 discontinuation of the last coverage that is discontinued.  
265 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the  
266 commissioner finds that waiver is in the public interest:  
267 (i) to promote competition; or  
268 (ii) to resolve inequity in the marketplace.  
269 (9) If an insurer is doing business in one established geographic service area of the  
270 state, this section applies only to the insurer's operations in that geographic service area.  
271 (10) An insurer may modify a health benefit plan for a plan sponsor only:  
272 (a) at the time of coverage renewal; and  
273 (b) if the modification is effective uniformly among all plans with a particular product  
274 or service.  
275 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to

276 the employer:

277 (a) with respect to coverage provided to an employer member of the association; and

278 (b) if the health benefit plan is made available by an insurer in the employer market

279 only through:

280 (i) an association;

281 (ii) a trust; or

282 (iii) a discretionary group.

283 (12) (a) A small employer that, after purchasing a health benefit plan in the small group

284 market, employs on average more than 50 eligible employees on each business day in a

285 calendar year may continue to renew the health benefit plan purchased in the small group

286 market.

287 (b) A large employer that, after purchasing a health benefit plan in the large group

288 market, employs on average less than 51 eligible employees on each business day in a calendar

289 year may continue to renew the health benefit plan purchased in the large group market.

290 (13) An insurer offering employer sponsored health benefit plans shall comply with the

291 Health Insurance Portability and Accountability Act, P. L. 104-191, 110 Stat. 1962, Sec. 2701

292 and 2702.

292a **§ Section 4. Section 31A-29-106 is amended to read:**

292b **31A-29-106. Powers and duties of board.**

292c **(1) The board shall have the general powers and authority granted under the laws of this state**

292d **to insurance companies licensed to transact health care insurance business. In addition, the board**

292e **shall have the specific authority to:**

292f **(a) enter into contracts to carry out the provisions and purposes of this chapter, including,**

292g **with the approval of the commissioner, contracts with:**

292h **(i) similar pools of other states for the joint performance of common administrative functions;**

292i **or**

292j **(ii) persons or other organizations for the performance of administrative functions;**

292k **(b) sue or be sued, including taking such legal action necessary to avoid the payment of**

292l **improper claims against the pool or the coverage provided through the pool;**

292m **(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents'**

292n **referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of**

292o **the pool;**

292p **(d) issue policies of insurance in accordance with the requirements of this chapter;**

292q **(e) retain an executive director and appropriate legal, actuarial, and other personnel as**

292r **necessary to provide technical assistance in the operations of the pool;**

292s **(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;**

292t **(g) cause the pool to have an annual audit of its operations by the state auditor; §**

292u           § (h) coordinate with the Department of Health in seeking to obtain from the Centers for  
 292v Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate  
 292w waivers, authority, and permission needed to coordinate the coverage available from the pool with  
 292x coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion  
 292y option upon completion of Medicaid eligibility, without the necessity for requalification by the  
 292z enrollee;

292aa           (i) provide for and employ cost containment measures and requirements including  
 292ab preadmission certification, concurrent inpatient review, and individual case management for the  
 292ac purpose of making the pool more cost-effective;

292ad           (j) offer pool coverage through contracts with health maintenance organizations, preferred  
 292ae provider organizations, and other managed care systems that will manage costs while maintaining  
 292af quality care;

292ag           (k) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

292ah           (l) exclude from coverage under the pool specific benefits, medical conditions, and  
 292ai procedures for the purpose of protecting the financial viability of the pool;

292aj           (m) administer the Pool Fund;

292ak           (n) make rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act,  
 292al to implement this chapter; and

292am           (o) adopt, trademark, and copyright a trade name for the pool for use in marketing and  
 292an publicizing the pool and its products.

292ao           (2) (a) The board shall prepare and submit an annual report to the Legislature which shall  
 292ap include:

292aq           (i) the net premiums anticipated;

292ar           (ii) actuarial projections of payments required of the pool;

292as           (iii) the expenses of administration; and

292at           (iv) the anticipated reserves or losses of the pool.

292au           (b) The budget for operation of the pool is subject to the approval of the board.

292av           (c) The administrative budget of the board and the commissioner under this chapter shall  
 292aw comply with the requirements of Title 63, Chapter 38, Budgetary Procedures Act, and is subject to  
 292ax review and approval by the Legislature.

292ay           **(3) (a) THE BOARD SHALL ON OR BEFORE SEPTEMBER 1, 2004, REQUIRE THE PLAN**  
 292az **ADMINISTRATOR OR AN INDEPENDENT ACTUARIAL CONSULTANT RETAINED BY THE PLAN**  
 292ba **ADMINISTRATOR TO REDETERMINE THE REASONABLE EQUIVALENT OF THE CRITERIA FOR**  
 292bb **UNINSURABILITY REQUIRED UNDER SUBSECTION 31A-30-106(j) THAT IS USED BY THE BOARD TO**  
 292bc **DETERMINE ELIGIBILITY FOR COVERAGE IN THE POOL.**

292bd           **(b) THE BOARD SHALL REDETERMINE THE CRITERIA ESTABLISHED IN SUBSECTION (3)(a)**  
 292be **AT LEAST EVERY FIVE YEARS THEREAFTER. §**

293           Section 4. Section 31A-29-113 is amended to read:

294           **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**  
 295 **conditions -- Waiver -- Maximum benefits.**

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

298 (i) exceed the deductible and copayment amounts applicable under Section  
299 31A-29-114; and

300 (ii) are not otherwise limited or excluded.

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

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

306 (3) The commissioner shall approve the benefit package developed by the board to

307 ensure its compliance with this chapter.

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

310 (5) This chapter may not be construed to prohibit the pool from issuing additional types  
311 of pool policies with different types of benefits which in the opinion of the board may be of  
312 benefit to the citizens of Utah.

313 (6) The board shall design and require an administrator to employ cost containment  
314 measures and requirements including preadmission certification and concurrent inpatient  
315 review for the purpose of making the pool more cost effective. The provisions of Sections  
316 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

317 (7) (a) A pool policy may contain provisions under which coverage for a preexisting  
318 condition is excluded during a six-month period following the effective date of plan coverage  
319 for a given individual.

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

321 (8) A pool policy may exclude coverage for pregnancies for ten months following the  
322 effective date of coverage, unless the individual is HIPAA eligible.

323 (9) (a) The pool will waive the preexisting condition exclusion described in Subsection  
324 (7)(a) for an individual that is changing health coverage to the pool, to the extent to which  
325 similar exclusions have been satisfied under any prior health insurance coverage if~~[(i)]~~ the  
326 individual applies not later than 63 days following the date of involuntary termination, other  
327 than for nonpayment of premiums, from health coverage~~[; or]~~.

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

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

333 (c) If this Subsection (9) applies, coverage in the pool shall be effective from the date  
334 on which the prior coverage was terminated.

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

337 Section 5. Section **31A-30-107** is amended to read:

338           **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**  
339 **nonrenewal.**

340           (1) Except as otherwise provided in this section, a small employer health benefit plan is  
341 renewable and continues in force:

- 342           (a) with respect to all eligible employees and dependents; and
- 343           (b) at the option of the plan sponsor.

344           (2) A small employer health benefit plan may be discontinued or nonrenewed:

345           (a) for a network plan, if:

346           (i) there is no longer any enrollee under the group health plan who lives, resides, or  
347 works in:

348           (A) the service area of the covered carrier; or

349           (B) the area for which the covered carrier is authorized to do business; and

350           (ii) in the case of the small employer market, the small employer carrier applies the  
351 same criteria the small employer carrier would apply in denying enrollment in the plan under  
352 Subsection 31A-30-108[~~(6)~~] (7); or

353           (b) for coverage made available in the small or large employer market only through an  
354 association, if:

355           (i) the employer's membership in the association ceases; and

356           (ii) the coverage is terminated uniformly without regard to any health status-related  
357 factor relating to any covered individual.

358           (3) A small employer health benefit plan may be discontinued if:

359           (a) a condition described in Subsection (2) exists;

360           (b) the plan sponsor fails to pay premiums or contributions in accordance with the  
361 terms of the contract;

362           (c) the plan sponsor:

363           (i) performs an act or practice that constitutes fraud; or

364           (ii) makes an intentional misrepresentation of material fact under the terms of the  
365 coverage;

366           (d) the covered carrier:

367           (i) elects to discontinue offering a particular small employer health benefit product  
368 delivered or issued for delivery in this state; and

- 369 (ii) (A) provides notice of the discontinuation in writing:  
370 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and  
371 (II) at least 90 days before the date the coverage will be discontinued;
- 372 (B) provides notice of the discontinuation in writing:  
373 (I) to the commissioner; and  
374 (II) at least three working days prior to the date the notice is sent to the affected plan  
375 sponsors, employees, and dependents of the plan sponsors or employees;
- 376 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all  
377 other small employer health benefit products currently being offered by the small employer  
378 carrier in the market; and
- 379 (D) in exercising the option to discontinue that product and in offering the option of  
380 coverage in this section, acts uniformly without regard to:
- 381 (I) the claims experience of a plan sponsor;  
382 (II) any health status-related factor relating to any covered participant or beneficiary; or  
383 (III) any health status-related factor relating to any new participant or beneficiary who  
384 may become eligible for the coverage; or
- 385 (e) the covered carrier:  
386 (i) elects to discontinue all of the covered carrier's small employer health benefit plans  
387 in:
- 388 (A) the small employer market;  
389 (B) the large employer market; or  
390 (C) both the small employer and large employer markets; and
- 391 (ii) (A) provides notice of the discontinuation in writing:  
392 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and  
393 (II) at least 180 days before the date the coverage will be discontinued;
- 394 (B) provides notice of the discontinuation in writing:  
395 (I) to the commissioner in each state in which an affected insured individual is known  
396 to reside; and  
397 (II) at least 30 working days prior to the date the notice is sent to the affected plan  
398 sponsors, employees, and the dependents of the plan sponsors or employees;
- 399 (C) discontinues and nonrenews all plans issued or delivered for issuance in the

400 market; and

401 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

402 (4) A small employer health benefit plan may be discontinued or nonrenewed:

403 (a) if a condition described in Subsection (2) exists; or

404 (b) for noncompliance with the insurer's employer contribution requirements.

405 (5) A small employer health benefit plan may be nonrenewed:

406 (a) if a condition described in Subsection (2) exists; or

407 (b) for noncompliance with the insurer's minimum participation requirements.

408 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be  
409 discontinued if after issuance of coverage the eligible employee:

410 (i) engages in an act or practice that constitutes fraud in connection with the coverage;

411 or

412 (ii) makes an intentional misrepresentation of material fact in connection with the  
413 coverage.

414 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

415 (i) 12 months after the date of discontinuance; and

416 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
417 to reenroll.

418 (c) At the time the eligible employee's coverage is discontinued under Subsection  
419 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when  
420 coverage is discontinued.

421 (d) An eligible employee may not be discontinued under this Subsection (6) because of  
422 a fraud or misrepresentation that relates to health status.

423 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to  
424 the employer:

425 (a) with respect to coverage provided to an employer member of the association; and

426 (b) if the small employer health benefit plan is made available by a covered carrier in  
427 the employer market only through:

428 (i) an association;

429 (ii) a trust; or

430 (iii) a discretionary group.



- 431 (8) A covered carrier may modify a small employer health benefit plan only:  
 432 (a) at the time of coverage renewal; and  
 433 (b) if the modification is effective uniformly among all plans with that product.

434 Section 6. Section **31A-30-107.3** is amended to read:

435 **31A-30-107.3. Discontinuance and nonrenewal limitations and conditions.**

436 (1) (a) A carrier that elects to discontinue offering a health benefit plan under  
 437 Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e) is prohibited from writing new business:

- 438 (i) in the small employer and individual market in this state; and  
 439 (ii) for a period of five years beginning on the date of discontinuation of the last  
 440 coverage that is discontinued.

441 (b) The prohibition described in Subsection (1)(a) may be waived if the commissioner  
 442 finds that waiver is in the public interest:

- 443 (i) to promote competition; or  
 444 (ii) to resolve inequity in the marketplace.

445 (2) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A,  
 446 Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual  
 447 carrier:

448 (i) may elect to discontinue offering new individual health benefit plans, except to  
 449 HIPAA eligibles, but must keep existing individual health benefit plans in effect, except those  
 450 individual plans that are not renewed under the provisions of Subsection 31A-30-107(2) or  
 451 31A-30-107.1(2);

452 (ii) may elect to continue to offer new individual and small ~~Ê~~ **[employee]** **EMPLOYER** ~~ê~~  
 452a health benefit  
 453 plans; or

454 (iii) may elect to discontinue all of the covered carriers health benefit plans in the  
 455 individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or  
 456 31A-30-107.1(3)(e).

457 (b) A carrier that makes an election under Subsection (2)(a)(i) is:

458 (i) prohibited from writing new business;

459 (A) in the individual market in this state; and

460 (B) for a period of five years beginning on the date of discontinuation;

461 (ii) may continue to write new business in the small employer market; and

462 (iii) must provide written notice of the election under Subsection (2)(a)(i) within two  
463 calendar days of the election to the Utah Insurance Department.

464 (c) The prohibition described in Subsection (2)(b)(i) may be waived if the  
465 commissioner finds that waiver is in the public interest:

466 (i) to promote competition; or

467 (ii) to resolve inequity in the marketplace.

468 (d) A carrier that makes an election under Subsection (2)(a)(iii) is subject to the  
469 provisions of Subsection (1).

470 [~~2~~] (3) If a carrier is doing business in one established geographic service area of the  
471 state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that  
472 geographic service area.

473 [~~3~~] (4) If a small employer employs less than two employees, a carrier may not  
474 discontinue or not renew the health benefit plan until the first renewal date following the  
475 beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that  
476 the employer no longer has at least two current employees.

477 Section 7. Section **31A-30-108** is amended to read:

478 **31A-30-108. Eligibility for small employer and individual market.**

479 (1) (a) Small employer carriers shall accept residents for small group coverage as set  
480 forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962,  
481 Sec. 2701(f) and 2711(a).

482 (b) Individual carriers shall accept residents for individual coverage pursuant:

483 (i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and

484 (ii) Subsection (3).

485 (2) (a) Small employer carriers shall offer to accept all eligible employees and their  
486 dependents at the same level of benefits under any health benefit plan provided to a small  
487 employer.

488 (b) Small employer carriers may:

489 (i) request a small employer to submit a copy of the small employer's quarterly income  
490 tax withholdings to determine whether the employees for whom coverage is provided or  
491 requested are bona fide employees of the small employer; and

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

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

494 (3) Except as provided in [~~Subsection~~] Subsections (5) and (6) and Section  
495 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the  
496 following conditions apply:

497 (a) the individual is not covered or eligible for coverage:

498 (i) (A) as an employee of an employer;

499 (B) as a member of an association; or

500 (C) as a member of any other group; and

501 (ii) under:

502 (A) a health benefit plan; or

503 (B) a self-insured arrangement that provides coverage similar to that provided by a  
504 health benefit plan as defined in Section 31A-1-301;

505 (b) the individual is not covered and is not eligible for coverage under any public  
506 health benefits arrangement including:

507 (i) the Medicare program established under Title XVIII of the Social Security Act;

508 (ii) the Medicaid program established under Title XIX of the Social Security Act;

509 (iii) any act of Congress or law of this or any other state that provides benefits  
510 comparable to the benefits provided under this chapter; or

511 (iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter  
512 29, Comprehensive Health Insurance Pool Act;

513 (c) unless the maximum benefit has been reached the individual is not covered or  
514 eligible for coverage under any:

515 (i) Medicare supplement policy;

516 (ii) conversion option;

517 (iii) continuation or extension under COBRA; or

518 (iv) state extension;

519 (d) the individual has not terminated or declined coverage described in Subsection  
520 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for  
521 individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the  
522 requirement of this Subsection (3)(d) does not apply; and

523 (e) the individual is certified as ineligible for the Health Insurance Pool if:

524 (i) the individual applies for coverage with the Comprehensive Health Insurance Pool  
 525 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for  
 526 coverage with that covered carrier within 30 days after the date of issuance of a certificate  
 527 under Subsection 31A-29-111(4)(c); or

528 (ii) the individual applies for coverage with any individual carrier within 45 days after:

529 (A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

530 (B) the date of issuance of a certificate under Subsection 31A-29-111(4)(c) if the  
 531 individual applied first for coverage with the Comprehensive Health Insurance Pool.

532 (4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is  
 533 paid, the effective date of coverage shall be the first day of the month following the individual's  
 534 submission of a completed insurance application to that covered carrier.

535 (b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is  
 536 paid, the effective date of coverage shall be the day following the:

537 (i) cancellation of coverage under Subsection 31A-29-115(1); or

538 (ii) submission of a completed insurance application to the Comprehensive Health  
 539 Insurance Pool.

540 (5) (a) An individual carrier is not required to accept individuals for coverage under  
 541 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

542 (b) A carrier described in Subsection (5)(a) may not issue new individual policies in  
 543 the state for five years from July 1, 1997.

544 (c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new  
 545 policies after July 1, 1999, which may only be granted if:

546 (i) the carrier accepts uninsurables as is required of a carrier entering the market under  
 547 Subsection 31A-30-110; and

548 (ii) the commissioner finds that the carrier's issuance of new individual policies:

549 (A) is in the best interests of the state; and

550 (B) does not provide an unfair advantage to the carrier.

551 (6) (a) If  $\hat{H}$  [enrollment in]  $\hat{h}$  the Comprehensive Health Insurance Pool as set forth under  
 552 Title 31A, Chapter 29, is  $\hat{H}$  DISSOLVED OR DISCONTINUED, OR IF ENROLLMENT IS  $\hat{h}$  capped or  
 552a suspended, an individual carrier may decline to accept  
 553 individuals applying for individual enrollment, other than individuals applying for coverage as  
 554 set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b).

555 (b) Within two calendar days of taking action under Subsection (6)(a), an individual  
 556 carrier will provide written notice to the Utah Insurance Department.

557 [~~(6)~~] (7) (a) If a small employer carrier offers health benefit plans to small employers  
 558 through a network plan, the small employer carrier may:

559 (i) limit the employers that may apply for the coverage to those employers with eligible  
 560 employees who live, reside, or work in the service area for the network plan; and

561 (ii) within the service area of the network plan, deny coverage to an employer if the  
 562 small employer carrier has demonstrated to the commissioner that the small employer carrier:

563 (A) will not have the capacity to deliver services adequately to enrollees of any  
 564 additional groups because of the small employer carrier's obligations to existing group contract  
 565 holders and enrollees; and

566 (B) applies this section uniformly to all employers without regard to:

567 (I) the claims experience of an employer, an employer's employee, or a dependent of an  
 568 employee; or

569 (II) any health status-related factor relating to an employee or dependent of an  
 570 employee.

571 (b) (i) A small employer carrier that denies a health benefit product to an employer in  
 572 any service area in accordance with this section may not offer coverage in the small employer  
 573 market within the service area to any employer for a period of 180 days after the date the  
 574 coverage is denied.

575 (ii) This Subsection [~~(6)~~] (7)(b) does not:

576 (A) limit the small employer carrier's ability to renew coverage that is in force; or

577 (B) relieve the small employer carrier of the responsibility to renew coverage that is in  
 578 force.

579 (c) Coverage offered within a service area after the 180-day period specified in  
 580 Subsection [~~(6)~~] (7)(b) is subject to the requirements of this section.

581 **Section 8. Repealer.**

582 This bill repeals:

583 Section **31A-30-106.6, Individual rates.**

583a **§ Section 9. Effective date.**

583b **IF APPROVED BY TWO-THIRDS OF ALL THE MEMBERS ELECTED TO EACH HOUSE, THIS**  
 583c **BILL TAKES EFFECT UPON APPROVAL BY THE GOVERNOR, OR THE DAY FOLLOWING THE**  
 583d **CONSTITUTIONAL TIME LIMIT OF UTAH CONSTITUTION ARTICLE VII, SECTION 8, WITHOUT THE**  
 583e **GOVERNOR'S SIGNATURE, OR IN THE CASE OF A VETO, THE DATE OF VETO OVERRIDE.** §

**Legislative Review Note**  
as of 1-22-04 4:02 PM

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

**Office of Legislative Research and General Counsel**

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**Fiscal Note**  
**Bill Number HB0106**

**Health Insurance Act Amendments**

*27-Jan-04*

*2:57 PM*

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**State Impact**

No fiscal impact.

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**Individual and Business Impact**

Individual and business fiscal impacts will vary according to circumstances. The bill makes provision for capping or failure of the Comprehensive Health Insurance Pool.

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**Office of the Legislative Fiscal Analyst**