LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: C.J. Dupont ₵
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HEALTH INSURANCE AMENDMENTS

2007 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Gene Davis

LONG TITLE

General Description:

This bill amends the Comprehensive Health Insurance Pool Act.

Highlighted Provisions:

This bill:

- makes technical amendments to the definition of insurer;
- deletes obsolete language;
- amends the lifetime benefit maximum; and
- amends eligibility for the high risk pool.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-29-103, as last amended by Chapter 78, Laws of Utah 2005

31A-29-104, as last amended by Chapter 2, Laws of Utah 2004

31A-29-110, as last amended by Chapter 78, Laws of Utah 2005

31A-29-111, as last amended by Chapter 78, Laws of Utah 2005

31A-29-113, as last amended by Chapter 78, Laws of Utah 2005

31A-29-117, as last amended by Chapter 168, Laws of Utah 2003

H.B. 80

31A-29-119, as last amended by Chapter 168, Laws of Utah 2003

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

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

31A-29-103. Definitions.

As used in this chapter:

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

(2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage, as defined in Section 31A-1-301.

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

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

(5) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(6) "Health care provider" has the same meaning as provided in Section 78-14-3.

(7) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(8) (a) "Health insurance" means any:

(i) hospital and medical expense-incurred policy;

(ii) nonprofit health care service plan contract; or

(iii) health maintenance organization subscriber contract.

(b) "Health insurance" does not mean:

(i) any insurance arising out of Title 34A, Chapter 2 or 3, or similar law;

(ii) automobile medical payment insurance; or

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

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

(10) (a) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(i) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(ii) coverage through:

(A) a health maintenance organization;

(B) a preferred provider prepayment;

(C) group practice; or

(D) individual practice plan;

(iii) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(iv) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(v) coverage by Medicare or other governmental benefit.

(b) "Health plan" includes coverage through health insurance.

(11) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

(12) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

(13) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state;

(b) a health maintenance organization; [~~and~~] or

(c) a self-insurer not subject to federal preemption.

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

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

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

(17) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

(18) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

(19) "Pool policy" means a health insurance policy issued under this chapter.

(20) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

(21) (a) "Resident" or "residency" means a person who is domiciled in this state.

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

(22) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

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

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

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

(2) The pool shall be under the direction of a board of directors composed of 12 members.

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

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

(ii) one representative of a health maintenance organization;

(iii) one physician;

(iv) one representative of hospitals;

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

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

(vii) one representative of the general public;

(viii) one representative of employers; and

(ix) one licensed producer with an accident and health line of authority.

(b) The board shall also include:

(i) the commissioner or the commissioner's designee; and

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

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

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

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

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

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

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

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

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

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

(7) Six board members are a quorum for the transaction of business.

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

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

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

Section 3. Section **31A-29-110** is amended to read:

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

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

(a) ability to manage medical expenses;

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

(c) efficiency of claim paying procedures;

(d) marketing and underwriting;

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

(f) provider contracting and discounts;

(g) pharmacy benefit management;

(h) an estimate of total charges for administering the pool; and

(i) ability to administer the pool in a cost-efficient manner.

(2) A pool administrator may be:

(a) a health insurer;

(b) a health maintenance organization;

(c) a third-party administrator; or

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

(3) (a) The pool administrator shall serve for a period of three years, with two one-year

extension options, subject to the terms, conditions, and limitations of the contract between the board and the administrator.

(b) At least one year prior to the expiration of the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator.

(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of [~~a three-year~~] the period of service [~~by the pool administrator~~] under Subsection (3)(a).

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

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

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

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

(d) perform all necessary functions to assure timely payment of benefits to enrollees, including:

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

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

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

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

(g) be paid as provided in the plan of operation for expenses incurred in the

performance of the pool administrator's services.

Section 4. Section **31A-29-111** is amended to read:

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

(1) (a) Except as provided in Subsections (1)(b) and (2), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

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

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

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

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(vi) the individual's health condition does not meet the criteria established under Subsection (5);

(vii) the individual is eligible for coverage under an employer group that offers health insurance or a self-insurance arrangement to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) the individual:

(A) has coverage substantially equivalent to a pool policy, as established by the board in administrative rule, either as an insured or a covered dependent; or

(B) would be eligible for the substantially equivalent coverage if the individual elected

to obtain the coverage; [~~or~~]

(ix) at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application[~~.~~]; or

(x) the individual's employer pays any part of the individual's health insurance premium, either as an insured or a dependent, for pool coverage.

(2) (a) Except as provided in Subsections (1) and (2)(b), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsections (1) and (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(iii) the individual is covered under any other health insurance;

(iv) the individual is eligible for coverage under an employer group that offers health insurance or self-insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

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

(vi) the individual is an inmate of a public institution[~~.~~]; or

(vii) the individual's employer pays any part of the individual's health insurance premium, either as an insured or a dependent, for pool coverage.

(3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

(b) Coverage sought under Subsection (3)(a) shall be applied for within 63 days after

the termination date of the previous high risk pool coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

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

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

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

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

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

(i) health condition; and

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

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).

(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).

Section 5. Section **31A-29-113** is amended to read:

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

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

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

(ii) are not otherwise limited or excluded.

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

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

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

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

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

(6) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

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

(8) (a) A pool policy may contain provisions under which coverage for a preexisting

pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

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

(10) Covered benefits available from the pool may not exceed a [~~$1,000,000~~] $2,000,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 6. Section **31A-29-117** is amended to read:

31A-29-117. Premium rates.

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

(i) the benefits provided;

(ii) the risk experience; and

(iii) the reasonable expenses provided in the coverage.

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

(2) [~~A small~~] Small employer [~~carrier~~] carriers, as defined in Section [~~31A-1-301~~] 31A-30-103, shall annually inform the commissioner by [~~April~~] February 1 of the carrier's:

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

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

(3) (a) Premium rates may be adjusted by the board on a biannual basis, for an effective date of January 1 and July 1.

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

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

(ii) be subject to Subsection (1).

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

(5) If an individual is HIPAA eligible, the maximum premium rate for that individual may not exceed the amount permitted under HIPAA.

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

Section 7. Section **31A-29-119** is amended to read:

31A-29-119. Benefit reduction.

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

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

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

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

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

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

Legislative Review Note
as of 12-19-06 2:28 PM

Office of Legislative Research and General Counsel

Fiscal Note

H.B. 80 - Health Insurance Amendments

2007 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations. However, in 3 to 4 years the pool would experience increased costs of about $125,000 per qualifying individual due to the increased spending limit. Persons reaching the new maximum would result in savings to the pool.

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals, businesses, or local governments. However, in three to four years the new limit will allow affected individuals an additional 4 to 8 years of coverage. Individuals reaching the new limit will lose coverage. Individuals having an employer pay all or part of their premiums will cease to qualify for the pool.

1/9/2007, 11:11:59 AM, Lead Analyst: Eckersley, S.

Office of the Legislative Fiscal Analyst