1 **EMPLOYER HEALTH INSURANCE OPTIONS -**
2 **CAFETERIA PLANS**
3 2007 GENERAL SESSION
4 STATE OF UTAH
5 **Chief Sponsor: Michael G. Waddoups**
6 House Sponsor: ____________
7
8 **LONG TITLE**
9 **General Description:**
10 This bill amends the Insurance Code to require certain health insurers to offer a swing
11 out option to employers and employees.
12 **Highlighted Provisions:**
13 This bill:
14 ▸ defines terms;
15 ▸ beginning July 1, 2007, requires health insurers to offer to employers a swing out
16 option;
17 ▸ if an employer chooses a swing out option, requires an insurer to inform employees
18 of the swing out option;
19 ▸ permits an employer to pass the cost of a swing out option on to the employee;
20 ▸ establishes a reimbursement rate for noncontracted providers;
21 ▸ establishes certain requirements for applying out-of-pocket expenses;
22 ▸ prohibits an insurer from discriminating against a health care provider under
23 contract with the insurer when the health care provider refers patients with a swing
24 out option out of network;
25 ▸ requires the Insurance Department to report by November 2010 to the legislative
26 Business and Labor Interim Committee concerning swing out options in the state;
27 ▸ coordinates requirements of the swing out option with the preferred provider

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28 contract provisions; and
29 ▸ makes technical changes.
30 **Monies Appropriated in this Bill:**
31 None
32 **Other Special Clauses:**
33 None
34 **Utah Code Sections Affected:**
35 AMENDS:
36 **31A-8-103**, as last amended by Chapters 2 and 90, Laws of Utah 2004
37 **31A-30-108**, as last amended by Chapters 2 and 329, Laws of Utah 2004
38 ENACTS:
39 **31A-22-635**, Utah Code Annotated 1953
40

41 *Be it enacted by the Legislature of the state of Utah:*
42 Section 1. Section **31A-8-103** is amended to read:
43 **31A-8-103. Applicability to other provisions of law.**
44 (1) (a) Except for exemptions specifically granted under this title, an organization is
45 subject to regulation under all of the provisions of this title.
46 (b) Notwithstanding any provision of this title, an organization licensed under this
47 chapter:
48 (i) is wholly exempt from:
49 (A) Chapter 7, Nonprofit Health Service Insurance Corporations;
50 (B) Chapter 9, Insurance Fraternals;
51 (C) Chapter 10, Annuities;
52 (D) Chapter 11, Motor Clubs;
53 (E) Chapter 12, State Risk Management Fund;
54 (F) Chapter 13, Employee Welfare Funds and Plans;
55 (G) Chapter 19a, Utah Rate Regulation Act; and
56 (H) Chapter 28, Guaranty Associations; and
57 (ii) is not subject to:
58 (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1;

59 (B) Section 31A-4-107;
60 (C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for
61 provisions specifically made applicable by this chapter;
62 (D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by
63 this chapter;
64 (E) Chapter 17, Determination of Financial Condition, except:
65 (I) Parts 2 and 6; or
66 (II) as made applicable by the commissioner by rule consistent with this chapter;
67 (F) Chapter 18, Investments, except as made applicable by the commissioner by rule
68 consistent with this chapter; and
69 (G) Chapter 22, Contracts in Specific Lines, except for Parts 6, 7, and 12.
70 (2) The commissioner may by rule waive other specific provisions of this title that the
71 commissioner considers inapplicable to health maintenance organizations or limited health
72 plans, upon a finding that the waiver will not endanger the interests of:
73 (a) enrollees;
74 (b) investors; or
75 (c) the public.
76 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,
77 Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as
78 specifically made applicable by:
79 (a) this chapter;
80 (b) a provision referenced under this chapter; or
81 (c) a rule adopted by the commissioner to deal with corporate law issues of health
82 maintenance organizations that are not settled under this chapter.
83 (4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an
84 organization, the application is:
85 (i) of those provisions that apply to a mutual corporation if the organization is
86 nonprofit; and
87 (ii) of those that apply to a stock corporation if the organization is for profit.
88 (b) When Chapter 5 or 14 is made applicable to an organization under this chapter,
89 "mutual" means nonprofit organization.

90 (5) Solicitation of enrollees by an organization is not a violation of any provision of
91 law relating to solicitation or advertising by health professionals if that solicitation is made in
92 accordance with:
93 (a) this chapter; and
94 (b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
95 Reinsurance Intermediaries.
96 (6) This title does not prohibit any health maintenance organization from meeting the
97 requirements of any federal law that enables the health maintenance organization to:
98 (a) receive federal funds; or
99 (b) obtain or maintain federal qualification status.
100 (7) (a) Except as provided in Section 31A-8-501, and Subsection (7)(b), an
101 organization is exempt from statutes in this title or department rules that restrict or limit the
102 organization's freedom of choice in contracting with or selecting health care providers,
103 including Section 31A-22-618.
104 (b) An organization shall offer a swing out option in compliance with Section
105 31A-22-635.
106 (8) An organization is exempt from the assessment or payment of premium taxes
107 imposed by Sections 59-9-101 through 59-9-104.
108 Section 2. Section **31A-22-635** is enacted to read:
109 **31A-22-635. Offer of swing out option.**
110 (1) For purposes of this section:
111 (a) "Class of health care provider" means all health care providers as defined in Section
112 78-14-3:
113 (i) who are licensed or certified by the state under either:
114 (A) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
115 (B) Title 58, Occupations and Professions; and
116 (ii) who are within the same professional, trade, occupational, or facility licensure or
117 certification category established pursuant to Title 26, Chapter 21, Health Care Facility
118 Licensing and Inspection Act, and Title 58 Occupations and Professions.
119 (b) "Employer" means an employer with 25 or more employees.
120 (c) "Fee schedule rate" means the total amount a contracted or participating provider is

121 entitled to receive for covered services regardless of how the responsibility for payment is
122 divided between the insurer and the insured.
123 (d) "Swing out option" means a health insurance plan or rider to a health insurance
124 plan under which the insurer will reimburse a health care provider for providing covered
125 services to an insured, without regard to whether the health care provider is a participating
126 provider or belongs to the health insurance plan network.
127 (2) (a) This section applies to an insurer who is subject to:
128 (i) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
129 (ii) Chapter 22, Part 6, Accident and Health Insurance;
130 (iii) Chapter 30, Individual, Small Employer, and Group Health Insurance Act, to the
131 extent required by Subsection (1)(b); and
132 (iv) notwithstanding Section 31A-1-103, Title 49, Chapter 20, Public Employees'
133 Benefit and Insurance Program Act.
134 (b) This section does not apply when an individual's health maintenance organization
135 benefit plan or health insurance plan is a Medicaid program or the Children's Health Insurance
136 Program under Title 26, Chapter 18, Medicaid Assistance Act.
137 (3) (a) (i) Beginning with policies issued after or renewed after July 1, 2007, an insurer
138 subject to Subsection (2)(a) shall offer at least one swing out option in accordance with this
139 section.
140 (ii) (A) An insurer shall offer a swing out option to every employer which would allow
141 an enrollee to receive covered services from out-of-network health care providers without
142 having to obtain a referral or prior authorization from the insurer.
143 (B) An insurer shall provide each enrollee in a plan whose employer elects the swing
144 out option, with the opportunity, at the time of enrollment and during the open enrollment
145 period, to enroll in the swing-out option. The insurer shall provide written notice of the
146 swing-out option to each enrollee in a plan whose employer elects the swing-out option and
147 shall include in that notice detailed explanation of the financial costs to be incurred by an
148 enrollee who selects that plan.
149 (iii) Any premium differential associated with the swing out option:
150 (A) shall be verified by an independent actuary;
151 (B) shall be explained to the employer in writing; and

152 (C) is limited to 10% above the premium the insurer charges for the health plan offered
153 to the employer.
154 (iv) (A) The insurer shall file a copy of the independent actuary's verification of the
155 premium differential with the commission.
156 (B) The commission may audit any records necessary to determine compliance with
157 this section.
158 (v) An employer may chose to pay any, all, or no part of additional cost that is
159 associated with an employee's selection of a swing out option.
160 (b) (i) By June 1, 2007, the department shall adopt administrative rules that establish
161 permissible standards for determining a premium differential for a swing out option under the
162 provisions of Subsection (3)(a)(iii).
163 (ii) The commissioner shall report to the Legislature's Business and Labor Interim
164 Committee by November 1, 2010 concerning:
165 (A) the number of swing out options offered in the state;
166 (B) the number of lives covered by swing out options in the state; and
167 (C) premium differentials for the swing out options offered in the state.
168 (c) A swing out option required by this section shall pay for covered services provided
169 by a nonparticipating provider as follows:
170 (i) pay an amount equal to 85% of the fee schedule rate that would be paid to the
171 insured for covered services by a participating provider who is a member of the same class of
172 health care provider;
173 (ii) pay the provider directly for the services; and
174 (iii) calculate and apply deductibles and cost sharing in accordance with Subsection
175 (4).
176 (4) (a) A swing out option subject to this section:
177 (i) may require that an enrollee pay a higher deductible or copayment and higher
178 premiums for the plan pursuant to Subsection (4)(b); and
179 (ii) may not require that an enrollee pay a separate deductible, separate copayment or
180 separate coinsurance for services provided by a noncontracted or nonparticipating provider.
181 (b) (i) Higher premiums associated with a swing out offer shall comply with:
182 (A) the provisions of Subsection (3)(a)(iii); and

183 (B) Subsection (4)(b)(ii)(B); and
184 (ii) higher copayments, coinsurance, and deductibles permitted by Subsection (4)(a)(i):
185 (A) may not exceed, in the aggregate, 150% of the copayments, coinsurance, and
186 deductibles required for contracted or participating providers; and
187 (B) are subject to other limits established by the department by administrative rule
188 adopted pursuant to Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
189 (5) When an insured receives services from a nonparticipating provider who is
190 reimbursed under the provisions of Subsection (3), the insured is responsible for:
191 (a) any copayments or deductibles that are imposed by the insurer under Subsection
192 (4); and
193 (b) in accordance with Subsection (6), the balance of provider charges that are not
194 reimbursed by the insurer.
195 (6) Notwithstanding any other section of this title, a provider who accepts direct
196 payment for health care services from an insurer may not collect from an insured an amount
197 that exceeds the insurer's fee schedule rate unless the insured has been informed of and agreed
198 to in writing, the specific cost of the service.
199 (7) An insurer subject to this section may not discriminate against a health care
200 provider based on a health care provider's referral patterns for patients who are covered by a
201 swing out option.
202 (8) (a) Except as provided in this Subsection (8) and Section 31A-8-103, an insurer
203 regulated by Chapter 22, Part 6, Accident and Health Insurance, must comply with Section
204 31A-22-617.
205 (b) When reimbursing under a swing out option required by this section:
206 (i) the reimbursement provisions of Subsection (3) of this section supercede the
207 reimbursement provisions in Subsection 31A-22-617(2)(b);
208 (ii) the cost sharing provisions of Subsection (4) supercede Subsection
209 31A-22-617(2)(d); and
210 (iii) the requirement for payment directly to the provider in Subsection (3)(c)(ii)
211 supercedes Subsection 31A-22-617(2)(c).
212 (9) The department may require an insurer to submit information to the department to
213 demonstrate compliance with this section.

214 Section 3. Section **31A-30-108** is amended to read:

215 **31A-30-108. Eligibility for small employer and individual market.**

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

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

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

221 (ii) Subsection (3).

222 (2) (a) [~~Small~~] Except as provided in Section 31A-22-635, small employer carriers
223 shall offer to accept all eligible employees and their dependents at the same level of benefits
224 under any health benefit plan provided to a small employer.

225 (b) Small employer carriers may:

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

229 (ii) deny or terminate coverage if the small employer refuses to provide documentation
230 requested under Subsection (2)(b)(i).

231 (3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual
232 carriers shall accept for coverage individuals to whom all of the following conditions apply:

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

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

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

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

237 (ii) under:

238 (A) a health benefit plan; or

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

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

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

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

245 (iii) any act of Congress or law of this or any other state that provides benefits
246 comparable to the benefits provided under this chapter; or
247 (iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter
248 29, Comprehensive Health Insurance Pool Act;
249 (c) unless the maximum benefit has been reached the individual is not covered or
250 eligible for coverage under any:
251 (i) Medicare supplement policy;
252 (ii) conversion option;
253 (iii) continuation or extension under COBRA; or
254 (iv) state extension;
255 (d) the individual has not terminated or declined coverage described in Subsection
256 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for
257 individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the
258 requirement of this Subsection (3)(d) does not apply; and
259 (e) the individual is certified as ineligible for the Health Insurance Pool if:
260 (i) the individual applies for coverage with the Comprehensive Health Insurance Pool
261 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for
262 coverage with that covered carrier within 30 days after the date of issuance of a certificate
263 under Subsection 31A-29-111 (5)(c); or
264 (ii) the individual applies for coverage with any individual carrier within 45 days after:
265 (A) notice of cancellation of coverage under Subsection 31A-29-115(1); or
266 (B) the date of issuance of a certificate under Subsection 31A-29-111 (5)(c) if the
267 individual applied first for coverage with the Comprehensive Health Insurance Pool.
268 (4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is
269 paid, the effective date of coverage shall be the first day of the month following the individual's
270 submission of a completed insurance application to that covered carrier.
271 (b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is
272 paid, the effective date of coverage shall be the day following the:
273 (i) cancellation of coverage under Subsection 31A-29-115(1); or
274 (ii) submission of a completed insurance application to the Comprehensive Health
275 Insurance Pool.

276 (5) (a) An individual carrier is not required to accept individuals for coverage under
277 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.
278 (b) A carrier described in Subsection (5)(a) may not issue new individual policies in
279 the state for five years from July 1, 1997.
280 (c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new
281 policies after July 1, 1999, which may only be granted if:
282 (i) the carrier accepts uninsurables as is required of a carrier entering the market under
283 Subsection 31A-30-110; and
284 (ii) the commissioner finds that the carrier's issuance of new individual policies:
285 (A) is in the best interests of the state; and
286 (B) does not provide an unfair advantage to the carrier.
287 (6) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A,
288 Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual
289 carrier may decline to accept individuals applying for individual enrollment, other than
290 individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741
291 (a)-(b).
292 (b) Within two calendar days of taking action under Subsection (6)(a), an individual
293 carrier will provide written notice to the Utah Insurance Department.
294 (7) (a) If a small employer carrier offers health benefit plans to small employers
295 through a network plan, the small employer carrier may:
296 (i) limit the employers that may apply for the coverage to those employers with eligible
297 employees who live, reside, or work in the service area for the network plan; and
298 (ii) within the service area of the network plan, deny coverage to an employer if the
299 small employer carrier has demonstrated to the commissioner that the small employer carrier:
300 (A) will not have the capacity to deliver services adequately to enrollees of any
301 additional groups because of the small employer carrier's obligations to existing group contract
302 holders and enrollees; and
303 (B) applies this section uniformly to all employers without regard to:
304 (I) the claims experience of an employer, an employer's employee, or a dependent of an
305 employee; or
306 (II) any health status-related factor relating to an employee or dependent of an

307 employee.

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

312 (ii) This Subsection (7)(b) does not:

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

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

316 (c) Coverage offered within a service area after the 180-day period specified in
317 Subsection (7)(b) is subject to the requirements of this section.

Legislative Review Note
as of 1-17-07 10:25 AM

Office of Legislative Research and General Counsel