Senator Michael G. Waddoups proposes the following substitute bill:

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 Cosponsors: Gene Davis Ed Mayne
8 D. Chris Buttars Margaret Dayton Dennis E. Stowell
9 Allen M. Christensen John W. Hickman

10

11 **LONG TITLE**
12 **General Description:**
13 This bill amends the Insurance Code to require certain health insurers to offer a point of
14 service plan to employers and employees.
15 **Highlighted Provisions:**
16 This bill:
17 ▸ defines terms;
18 ▸ beginning July 1, 2007, requires health insurers to offer to employers a point of
19 service plan;
20 ▸ if an employer chooses a point of service plan, requires an insurer to inform
21 employees of the point of service plan;
22 ▸ permits an employer to pass the cost of a point of service plan on to the employee;
23 ▸ establishes a reimbursement rate for noncontracted providers;
24 ▸ establishes certain requirements for applying out-of-pocket expenses;
25 ▸ prohibits an insurer from discriminating against a health care provider under

26 contract with the insurer when the health care provider refers patients with a point of service
27 plan out of network;
28 ▸ requires the Insurance Department to report by November 2010 to the legislative
29 Business and Labor Interim Committee concerning point of service plans in the
30 state;
31 ▸ coordinates requirements of the point of service plan with the preferred provider
32 contract provisions; and
33 ▸ makes technical changes.
34 **Monies Appropriated in this Bill:**
35 None
36 **Other Special Clauses:**
37 This bill coordinates with H.B. 163, Options for Health Care, by substantively and
38 technically modifying language.
39 **Utah Code Sections Affected:**
40 AMENDS:
41 **31A-8-103**, as last amended by Chapters 2 and 90, Laws of Utah 2004
42 ENACTS:
43 **31A-22-635**, Utah Code Annotated 1953
44

45 *Be it enacted by the Legislature of the state of Utah:*
46 Section 1. Section **31A-8-103** is amended to read:
47 **31A-8-103. Applicability to other provisions of law.**
48 (1) (a) Except for exemptions specifically granted under this title, an organization is
49 subject to regulation under all of the provisions of this title.
50 (b) Notwithstanding any provision of this title, an organization licensed under this
51 chapter:
52 (i) is wholly exempt from:
53 (A) Chapter 7, Nonprofit Health Service Insurance Corporations;
54 (B) Chapter 9, Insurance Fraternals;
55 (C) Chapter 10, Annuities;
56 (D) Chapter 11, Motor Clubs;

57 (E) Chapter 12, State Risk Management Fund;
58 (F) Chapter 13, Employee Welfare Funds and Plans;
59 (G) Chapter 19a, Utah Rate Regulation Act; and
60 (H) Chapter 28, Guaranty Associations; and
61 (ii) is not subject to:
62 (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1;
63 (B) Section 31A-4-107;
64 (C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for
65 provisions specifically made applicable by this chapter;
66 (D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by
67 this chapter;
68 (E) Chapter 17, Determination of Financial Condition, except:
69 (I) Parts 2 and 6; or
70 (II) as made applicable by the commissioner by rule consistent with this chapter;
71 (F) Chapter 18, Investments, except as made applicable by the commissioner by rule
72 consistent with this chapter; and
73 (G) Chapter 22, Contracts in Specific Lines, except for Parts 6, 7, and 12.
74 (2) The commissioner may by rule waive other specific provisions of this title that the
75 commissioner considers inapplicable to health maintenance organizations or limited health
76 plans, upon a finding that the waiver will not endanger the interests of:
77 (a) enrollees;
78 (b) investors; or
79 (c) the public.
80 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,
81 Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as
82 specifically made applicable by:
83 (a) this chapter;
84 (b) a provision referenced under this chapter; or
85 (c) a rule adopted by the commissioner to deal with corporate law issues of health
86 maintenance organizations that are not settled under this chapter.
87 (4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an

88 organization, the application is:
89 (i) of those provisions that apply to a mutual corporation if the organization is
90 nonprofit; and
91 (ii) of those that apply to a stock corporation if the organization is for profit.
92 (b) When Chapter 5 or 14 is made applicable to an organization under this chapter,
93 "mutual" means nonprofit organization.
94 (5) Solicitation of enrollees by an organization is not a violation of any provision of
95 law relating to solicitation or advertising by health professionals if that solicitation is made in
96 accordance with:
97 (a) this chapter; and
98 (b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
99 Reinsurance Intermediaries.
100 (6) This title does not prohibit any health maintenance organization from meeting the
101 requirements of any federal law that enables the health maintenance organization to:
102 (a) receive federal funds; or
103 (b) obtain or maintain federal qualification status.
104 (7) (a) Except as provided in Section 31A-8-501, and Subsection (7)(b), an
105 organization is exempt from statutes in this title or department rules that restrict or limit the
106 organization's freedom of choice in contracting with or selecting health care providers,
107 including Section 31A-22-618.
108 (b) An organization shall offer a point of service plan in compliance with Section
109 31A-22-635.
110 (8) An organization is exempt from the assessment or payment of premium taxes
111 imposed by Sections 59-9-101 through 59-9-104.
112 Section 2. Section **31A-22-635** is enacted to read:
113 **31A-22-635. Offer of point of service plan.**
114 (1) For purposes of this section:
115 (a) "Class of health care provider" means all health care providers as defined in Section
116 78-14-3:
117 (i) who are licensed or certified by the state under either:
118 (A) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

119 (B) Title 58, Occupations and Professions; and
120 (ii) who are within the same professional, trade, occupational, or facility licensure or
121 certification category established pursuant to Title 26, Chapter 21, Health Care Facility
122 Licensing and Inspection Act, and Title 58 Occupations and Professions.
123 (b) "Employer" means an employer with 2 or more employees.
124 (c) "Point of service plan" means a health insurance plan or rider to a health insurance
125 plan under which the insurer will reimburse a health care provider for providing covered
126 services to an insured, without regard to whether the health care provider is a participating
127 provider or belongs to the health insurance plan network.
128 (2) (a) This section applies to an insurer who is subject to:
129 (i) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
130 (ii) Chapter 22, Part 6, Accident and Health Insurance;
131 (iii) Chapter 30, Individual, Small Employer, and Group Health Insurance Act, to the
132 extent required by Subsection (1)(b); and
133 (iv) notwithstanding Section 31A-1-103, Title 49, Chapter 20, Public Employees'
134 Benefit and Insurance Program Act.
135 (b) This section does not apply when an individual's health maintenance organization
136 benefit plan or health insurance plan is a Medicaid program or the Children's Health Insurance
137 Program under Title 26, Chapter 18, Medicaid Assistance Act.
138 (3) (a) (i) Beginning with policies issued after or renewed after July 1, 2007, an insurer
139 subject to Subsection (2)(a) shall offer at least one point of service plan in accordance with this
140 section.
141 (ii) (A) An insurer shall offer a point of service plan to every employer which would
142 allow an enrollee to receive covered services from out-of-network health care providers
143 without having to obtain a referral or prior authorization from the insurer.
144 (B) An insurer shall provide each enrollee in a plan whose employer elects the point of
145 service plan, with the opportunity, at the time of enrollment and during the open enrollment
146 period, to enroll in the point of service plan. The insurer shall provide written notice of the
147 point of service plan to each enrollee in a plan whose employer elects the point of service plan
148 and shall include in that notice a detailed explanation of the financial costs to be incurred by an
149 enrollee who selects that plan.

150 (iii) The commission may audit any records necessary to determine compliance with
151 this section.
152 (iv) An employer may chose to pay any, all, or no part of additional cost that is
153 associated with an employee's selection of a point of service plan.
154 (b) The commissioner shall report to the Legislature's Business and Labor Interim
155 Committee by November 1, 2010 concerning:
156 (i) the number of point of service plans offered in the state; and
157 (ii) the number of lives covered by point of service plans in the state.
158 (c) A point of service plan required by this section shall pay for covered services
159 provided by a nonparticipating provider as follows:
160 (i) pay an amount equal to 75% of the average amount paid by the insurer for
161 comparable services of participating providers who are members of the same class of health
162 care provider;
163 (ii) pay the provider directly for the services; and
164 (iii) calculate and apply deductibles and cost sharing in accordance with Subsection
165 (4).
166 (4) (a) A point of service plan subject to this section:
167 (i) may require that an enrollee pay the added costs associated with a point of service
168 plan by paying higher deductibles and copayments pursuant to Subsection (4)(b);
169 (ii) may not require that an enrollee pay a separate deductible, separate copayment or
170 separate coinsurance for services provided by a noncontracted or nonparticipating provider; and
171 (iii) may not impose a higher premium for the point of service plan.
172 (b) Higher copayments, coinsurance, and deductibles permitted by Subsection (4)(a)(i):
173 (i) must be actuarially based; and
174 (ii) are subject to other limits established by the department by administrative rule
175 adopted pursuant to Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
176 (5) When an insured receives services from a nonparticipating provider who is
177 reimbursed under the provisions of Subsection (3), the insured is responsible for:
178 (a) any copayments or deductibles that are imposed by the insurer under Subsection
179 (4); and
180 (b) in accordance with Subsection (6), the balance of provider charges that are not

181 reimbursed by the insurer.
182 (6) Notwithstanding any other section of this title, a provider who accepts direct
183 payment for health care services from an insurer may not collect from an insured an amount
184 that exceeds the insurer's average reimbursement rate described in Subsection (3)(c)(i) unless
185 the insured has been informed of and agreed to in writing, the specific cost of the service.
186 (7) An insurer subject to this section may not discriminate against a health care
187 provider based on a health care provider's referral patterns for patients who are covered by a
188 point of service plan.
189 (8) (a) Except as provided in this Subsection (8) and Section 31A-8-103, an insurer
190 regulated by Chapter 22, Part 6, Accident and Health Insurance, must comply with Section
191 31A-22-617.
192 (b) When reimbursing under a point of service plan required by this section:
193 (i) the reimbursement provisions of Subsection (3) of this section supercede the
194 reimbursement provisions in Subsection 31A-22-617(2)(b);
195 (ii) the cost sharing provisions of Subsection (4) supercede Subsection
196 31A-22-617(2)(d); and
197 (iii) the requirement for payment directly to the provider in Subsection (3)(c)(ii)
198 supercedes Subsection 31A-22-617(2)(c).
199 (9) The department may require an insurer to submit information to the department to
200 demonstrate compliance with this section.
201 Section 3. **Coordinating H.B. 163 with S.B. 66 -- Modifying substantive language.**
202 If this S.B. 66 and H.B. 163 Options for Health Care, both pass, it is the intent of the
203 Legislature that the Office of Legislative Research and General Counsel in preparing the Utah
204 Code database for publication:
205 (1) delete Subsection 31A-22-635(8) in this bill, and renumber the remaining
206 Subsection; and
207 (2) amend Section 31A-22-617 by inserting a new a Subsection 31A-22-617(10)(d) to
208 read:
209 "(d) An insurer shall offer at least one policy that complies with Section 31A-22-635."
210