

1                   **COMPREHENSIVE HEALTH INSURANCE POOL**

2                                   **AMENDMENTS**

3   2008 GENERAL SESSION

4   STATE OF UTAH

5                                   **Chief Sponsor: James A. Dunnigan**

6                                   Senate Sponsor: Michael G. Waddoups

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**LONG TITLE**

8 **General Description:**

9                   This bill amends the Comprehensive Health Insurance Pool Act and the Individual,  
10                   Small Employer, and Group Health Insurance Act.

11 **Highlighted Provisions:**

12                   This bill:  
13                   ▶ makes technical amendments to the Comprehensive Health Insurance Pool Act;  
14                   ▶ amends provisions in the Individual, Small Employer, and Group Health Insurer Act  
15                   that relate to the Comprehensive Health Insurance Pool; and  
16                   ▶ increases the points required to be considered uninsurable.

17 **Monies Appropriated in this Bill:**

18                   None

19 **Other Special Clauses:**

20                   None

21 **Utah Code Sections Affected:**

22 **AMENDS:**

23                   **31A-29-102**, as last amended by Laws of Utah 2006, Chapter 95

24                   **31A-29-103**, as last amended by Laws of Utah 2007, Chapter 40

25                   **31A-29-111**, as last amended by Laws of Utah 2007, Chapter 40

26                   **31A-29-119**, as last amended by Laws of Utah 2007, Chapter 40



28 31A-30-106, as last amended by Laws of Utah 2004, Chapter 108



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

31 Section 1. Section 31A-29-102 is amended to read:

32 **31A-29-102. Purpose.**

33 The purpose of the Comprehensive Health Insurance Pool Act is to provide access to  
34 health care insurance coverage to residents of Utah who are denied adequate health care  
35 insurance and are considered uninsurable.

36 Section 2. Section 31A-29-103 is amended to read:

37 **31A-29-103. Definitions.**

38 As used in this chapter:

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

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

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

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

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

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

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

50 (5) "Health benefit plan":

51 (a) is defined in Section 31A-1-301; and

52 (b) does not include a plan that:

53 (i) ~~H→~~ (A) ~~←H~~ has a maximum actuarial value less than 100% of the basic health  
53a care plan; ~~H→~~ or

54 [(~~ii~~)] (B) ~~←H~~ has a maximum annual limit of \$100,000 or less; ~~H→~~ [~~or~~] and

55 [(~~iii~~)] (ii) ~~←H~~ meets other criteria established by the board.

56 [(~~5~~)] (6) "Health care facility" means any entity providing health care services which is  
57 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

58 (7) "Health care insurance" is defined in Section 31A-1-301.

59 ~~[(6)]~~ (8) "Health care provider" has the same meaning as provided in Section 78-14-3.

60 ~~[(7)]~~ (9) "Health care services" means:

61 (a) any service or product:

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

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

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

66 ~~[(8)(a) "Health insurance" means any:]~~

67 ~~[(i) hospital and medical expense-incurred policy;]~~

68 ~~[(ii) nonprofit health care service plan contract; or]~~

69 ~~[(iii) health maintenance organization subscriber contract.]~~

70 ~~[(b) "Health insurance" does not mean:]~~

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

72 ~~[(ii) automobile medical payment insurance; or]~~

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

75 ~~[(9)]~~ (10) "Health maintenance organization" has the same meaning as provided in  
76 Section 31A-8-101.

77 ~~[(10)(a)]~~ (11) "Health plan" means any arrangement by which an individual, including  
78 a dependent or spouse, covered or making application to be covered under the pool has:

79 ~~[(i)]~~ (a) access to hospital and medical benefits or reimbursement including group or  
80 individual insurance or subscriber contract;

81 ~~[(ii)]~~ (b) coverage through:

82 ~~[(A)]~~ (i) a health maintenance organization;

83 ~~[(B)]~~ (ii) a preferred provider prepayment;

84 ~~[(C)]~~ (iii) group practice; ~~[or]~~

85 ~~[(D)]~~ (iv) individual practice plan; or

86 (v) health care insurance;

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

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

93           ~~[(v)]~~ (e) coverage by Medicare or other governmental benefit.

94           ~~[(b) "Health plan" includes coverage through health insurance.]~~

95           ~~[(11)]~~ (12) "HIPAA" means the Health Insurance Portability and Accountability Act of  
96 1996, Pub. L. 104-191, 110 Stat. 1936.

97           ~~[(12)]~~ (13) "HIPAA eligible" means an individual who is eligible under the provisions  
98 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat.  
99 1936.

100           ~~[(13)]~~ (14) "Insurer" means:

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

103           (b) a health maintenance organization; or

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

105           ~~[(14)]~~ (15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42  
106 U.S.C. Sec. 1396 et seq., as amended.

107           ~~[(15)]~~ (16) "Medicare" means coverage under both Part A and B of Title XVIII of the  
108 Social Security Act, 42 U.S.C. 1395 et seq., as amended.

109           ~~[(16)]~~ (17) "Plan of operation" means the plan developed by the board in accordance  
110 with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the  
111 board under Section 31A-29-106.

112           ~~[(17)]~~ (18) "Pool" means the Utah Comprehensive Health Insurance Pool created in  
113 Section 31A-29-104.

114           ~~[(18)]~~ (19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise  
115 Fund created in Section 31A-29-120.

116           ~~[(19)]~~ (20) "Pool policy" means a health ~~[insurance]~~ benefit plan policy issued under  
117 this chapter.

118           ~~[(20)]~~ (21) "Preexisting condition" has the same meaning as defined in Section  
119 31A-1-301.

120           ~~[(21)]~~ (22) (a) "Resident" or "residency" means a person who is domiciled in this state.

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

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

123 (ii) for religious or educational purposes.

124 [~~(22)~~] (23) "Third-party administrator" has the same meaning as provided in Section

125 31A-1-301.

126 Section 3. Section **31A-29-111** is amended to read:

127 **31A-29-111. Eligibility -- Limitations.**

128 (1) (a) Except as provided in Subsection (1)(b), an individual who is not HIPAA

129 eligible is eligible for pool coverage if the individual:

130 (i) pays the established premium;

131 (ii) is a resident of this state; and

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

133 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not

134 eligible for pool coverage if one or more of the following conditions apply:

135 (i) the individual is eligible for health care benefits under Medicaid or Medicare,

136 except as provided in Section 31A-29-112;

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

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

139 (B) the individual demonstrates that creditable coverage has been involuntarily

140 terminated for any reason other than nonpayment of premium;

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

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

143 (v) the individual is eligible for a public health plan, as defined in federal regulations

144 adopted pursuant to 42 U.S.C. 300gg;

145 (vi) the individual's health condition does not meet the criteria established under

146 Subsection (5);

147 (vii) the individual is eligible for coverage under an employer group that offers a health

148 [~~insurance~~] benefit plan or a self-insurance arrangement to its eligible employees, dependents,

149 or members as:

150 (A) an eligible employee;

151 (B) a dependent of an eligible employee; or

152 (C) a member;

153 (viii) the individual[+] is covered under any other health benefit plan;

154 [~~(A) has coverage substantially equivalent to a pool policy, as established by the board~~

155 ~~in administrative rule, either as an insured or a covered dependent, or]~~

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

157 ~~to obtain the coverage;~~]

158 (ix) at the time of application, the individual has not resided in Utah for at least 12

159 consecutive months preceding the date of application; or

160 (x) the individual's employer pays any part of the individual's health [~~insurance~~] benefit

161 plan premium, either as an insured or a dependent, for pool coverage.

162 (2) (a) Except as provided in Subsection (2)(b), an individual who is HIPAA eligible is

163 eligible for pool coverage if the individual:

164 (i) pays the established premium; and

165 (ii) is a resident of this state.

166 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for

167 pool coverage if one or more of the following conditions apply:

168 (i) the individual is eligible for health care benefits under Medicaid or Medicare,

169 except as provided in Section 31A-29-112;

170 (ii) the individual is eligible for a public health plan, as defined in federal regulations

171 adopted pursuant to 42 U.S.C. 300gg;

172 (iii) the individual is covered under any other health [~~insurance~~] benefit plan;

173 (iv) the individual is eligible for coverage under an employer group that offers [~~health~~

174 ~~insurance~~] a health benefit plan or self-insurance arrangements to its eligible employees,

175 dependents, or members as:

176 (A) an eligible employee;

177 (B) a dependent of an eligible employee; or

178 (C) a member;

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

180 (vi) the individual is an inmate of a public institution; or

181 (vii) the individual's employer pays any part of the individual's health [~~insurance~~]

182 benefit plan premium, either as an insured or a dependent, for pool coverage.

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

187 (b) Coverage sought under Subsection (3)(a) shall be applied for within 63 days after  
188 the termination date of the previous high risk pool coverage.

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

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

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

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

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

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

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

205 (i) health condition; and

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

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

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

214 Section 4. Section **31A-29-119** is amended to read:

215 **31A-29-119. Benefit reduction.**

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

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

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

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

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

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

228 Section 5. Section **31A-30-106** is amended to read:

229 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**

230 (1) Premium rates for health benefit plans under this chapter are subject to the  
231 provisions of this Subsection (1).

232 (a) The index rate for a rating period for any class of business may not exceed the  
233 index rate for any other class of business by more than 20%.

234 (b) (i) For a class of business, the premium rates charged during a rating period to  
235 covered insureds with similar case characteristics for the same or similar coverage, or the rates  
236 that could be charged to such employers under the rating system for that class of business, may  
237 not vary from the index rate by more than 30% of the index rate, except as provided in Section  
238 31A-22-625.

239 (ii) A covered carrier that offers individual and small employer health benefit plans  
240 may use the small employer index rates to establish the rate limitations for individual policies,  
241 even if some individual policies are rated below the small employer base rate.

242 (c) The percentage increase in the premium rate charged to a covered insured for a new  
243 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
244 the following:



245 (i) the percentage change in the new business premium rate measured from the first day  
246 of the prior rating period to the first day of the new rating period;

247 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods  
248 of less than one year, due to the claim experience, health status, or duration of coverage of the  
249 covered individuals as determined from the covered carrier's rate manual for the class of  
250 business, except as provided in Section 31A-22-625; and

251 (iii) any adjustment due to change in coverage or change in the case characteristics of  
252 the covered insured as determined from the covered carrier's rate manual for the class of  
253 business.

254 (d) (i) Adjustments in rates for claims experience, health status, and duration from  
255 issue may not be charged to individual employees or dependents.

256 (ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the  
257 rates charged for all employees and dependents of the small employer.

258 (e) A covered carrier may use industry as a case characteristic in establishing premium  
259 rates, provided that the highest rate factor associated with any industry classification does not  
260 exceed the lowest rate factor associated with any industry classification by more than 15%.

261 (f) (i) Covered carriers shall apply rating factors, including case characteristics,  
262 consistently with respect to all covered insureds in a class of business.

263 (ii) Rating factors shall produce premiums for identical groups that:

264 (A) differ only by the amounts attributable to plan design; and

265 (B) do not reflect differences due to the nature of the groups assumed to select  
266 particular health benefit products.

267 (iii) A covered carrier shall treat all health benefit plans issued or renewed in the same  
268 calendar month as having the same rating period.

269 (g) For the purposes of this Subsection (1), a health benefit plan that uses a restricted  
270 network provision may not be considered similar coverage to a health benefit plan that does not  
271 use ~~[such]~~ a restricted network provision, provided that use of the restricted network provision  
272 results in substantial difference in claims costs.

273 (h) The covered carrier may not, without prior approval of the commissioner, use case  
274 characteristics other than:

275 (i) age;

276 (ii) gender;  
277 (iii) industry;  
278 (iv) geographic area;  
279 (v) family composition; and  
280 (vi) group size.

281 (i) (i) The commissioner [~~may~~] shall establish rules in accordance with Title 63,  
282 Chapter 46a, Utah Administrative Rulemaking Act, to:

283 (A) implement this chapter; and  
284 (B) assure that rating practices used by covered carriers are consistent with the  
285 purposes of this chapter.

286 (ii) The rules described in Subsection (1)(i)(i) may include rules that:

287 (A) assure that differences in rates charged for health benefit products by covered  
288 carriers are reasonable and reflect objective differences in plan design, not including  
289 differences due to the nature of the groups assumed to select particular health benefit products;  
290 (B) prescribe the manner in which case characteristics may be used by covered carriers;  
291 (C) implement the individual enrollment cap under Section 31A-30-110, including  
292 specifying:

293 (I) the contents for certification;  
294 (II) auditing standards;  
295 (III) underwriting criteria for uninsurable classification; and  
296 (IV) limitations on high risk enrollees under Section 31A-30-111; and  
297 (D) establish the individual enrollment cap under Subsection 31A-30-110(1).

298 (j) Before implementing regulations for underwriting criteria for uninsurable  
299 classification, the commissioner shall contract with an independent consulting organization to  
300 develop industry-wide underwriting criteria for uninsurability based on an individual's expected  
301 claims under open enrollment coverage exceeding [~~200%~~] 325% of that expected for a standard  
302 insurable individual with the same case characteristics.

303 (k) The commissioner shall revise rules issued for Sections 31A-22-602 and  
304 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance  
305 with this section.

306 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit

307 product into which the covered carrier is no longer enrolling new covered insureds, the covered  
308 carrier shall use the percentage change in the base premium rate, provided that the change does  
309 not exceed, on a percentage basis, the change in the new business premium rate for the most  
310 similar health benefit product into which the covered carrier is actively enrolling new covered  
311 insureds.

312 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of  
313 a class of business.

314 (b) A covered carrier may not offer to transfer a covered insured into or out of a class  
315 of business unless the offer is made to transfer all covered insureds in the class of business  
316 without regard:

- 317 (i) to case characteristics;
- 318 (ii) claim experience;
- 319 (iii) health status; or
- 320 (iv) duration of coverage since issue.

321 (4) (a) Each covered carrier shall maintain at the covered carrier's principal place of  
322 business a complete and detailed description of its rating practices and renewal underwriting  
323 practices, including information and documentation that demonstrate that the covered carrier's  
324 rating methods and practices are:

- 325 (i) based upon commonly accepted actuarial assumptions; and
- 326 (ii) in accordance with sound actuarial principles.

327 (b) (i) Each covered carrier shall file with the commissioner, on or before April 1 of  
328 each year, in a form, manner, and containing such information as prescribed by the  
329 commissioner, an actuarial certification certifying that:

- 330 (A) the covered carrier is in compliance with this chapter; and
- 331 (B) the rating methods of the covered carrier are actuarially sound.

332 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the  
333 covered carrier at the covered carrier's principal place of business.

334 (c) A covered carrier shall make the information and documentation described in this  
335 Subsection (4) available to the commissioner upon request.

336 (d) Records submitted to the commissioner under this section shall be maintained by  
337 the commissioner as protected records under Title 63, Chapter 2, Government Records Access

338 and Management Act.

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**Legislative Review Note**  
**as of 1-16-08 10:54 AM**

**Office of Legislative Research and General Counsel**

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**H.B. 301 - Comprehensive Health Insurance Pool Amendments**

**Fiscal Note**

2008 General Session

State of Utah

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**State Impact**

Enactment of this bill will not require additional appropriations.

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**Individual, Business and/or Local Impact**

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for businesses or local governments. Premiums for individuals may increase because they are no longer covered by the Utah's Comprehensive Health Insurance Pool.

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