LEGISLATIVE GENERAL COUNSEL
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H.B. 301

COMPREHENSIVE HEALTH INSURANCE POOL AMENDMENTS

2008 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Michael G. Waddoups

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

- makes technical amendments to the Comprehensive Health Insurance Pool Act;
- amends provisions in the Individual, Small Employer, and Group Health Insurer Act that relate to the Comprehensive Health Insurance Pool; and
- increases the points required to be considered uninsurable.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

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

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

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

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

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

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

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

31A-29-102. Purpose.

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

Section 2. 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 benefit plan":

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

(b) does not include a plan that:

(i) has a maximum actuarial value less that 100% of the basic health care plan;

(ii) has a maximum annual limit of $100,000 or less; or

(iii) meets other criteria established by the board.

[~~(5)~~] (6) "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.

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

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

[~~(7)~~] (9) "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)~~] (10) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

[~~(10) (a)~~] (11) "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)~~] (a) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

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

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

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

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

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

(v) health care insurance;

[~~(iii)~~] (c) 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)~~] (d) 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)~~] (e) coverage by Medicare or other governmental benefit.

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

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

[~~(12)~~] (13) "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)~~] (14) "Insurer" means:

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

(b) a health maintenance organization; or

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

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

[~~(15)~~] (16) "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)~~] (17) "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)~~] (18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

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

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

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

[~~(21)~~] (22) (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)~~] (23) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

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

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

(1) (a) Except as provided in Subsection (1)(b), 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 a health [~~insurance~~] benefit plan 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[~~:~~] is covered under any other health benefit plan;

[~~(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;~~]

(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~~] benefit plan premium, either as an insured or a dependent, for pool coverage.

(2) (a) Except as provided in Subsection (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 Subsection (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~~] benefit plan;

(iv) the individual is eligible for coverage under an employer group that offers [~~health insurance~~] a health benefit plan 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;

(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~~] benefit plan 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 care 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 4. 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~~] benefit plan 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 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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) age;

(ii) gender;

(iii) industry;

(iv) geographic area;

(v) family composition; and

(vi) group size.

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

(A) implement this chapter; and

(B) assure that rating practices used by covered carriers are consistent with the purposes of this chapter.

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

(A) assure that differences in rates charged for health benefit products by covered carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by covered carriers;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

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

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

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

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

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

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

(i) to case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

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

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

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

(A) the covered carrier is in compliance with this chapter; and

(B) the rating methods of the covered carrier are actuarially sound.

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

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

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

and Management Act.

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

Office of Legislative Research and General Counsel

H.B. 301 - Comprehensive Health Insurance Pool Amendments

Fiscal Note

2008 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations.

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.

1/24/2008, 8:35:54 AM, Lead Analyst: Schoenfeld, J.D.

Office of the Legislative Fiscal Analyst