1 # HEALTH SYSTEM REFORM - INSURANCE
2 # MARKET

3 2009 GENERAL SESSION
4 STATE OF UTAH

5 **Chief Sponsor: David Clark**
6 Senate Sponsor: Gregory S. Bell
7 Cosponsors: Brad L. Dee David Litvack
8 Roger E. Barrus Ben C. Ferry Merlynn T. Newbold
9 Ron Bigelow Kevin S. Garn Patrick Painter
10 Bradley M. Daw Bradley G. Last

11

12 **LONG TITLE**
13 **General Description:**
14 This bill amends the Insurance Code and the Governor's Office of Economic
15 Development Code to expand access to the health insurance market, increase market
16 flexibility, and provide greater transparency in the health insurance market.
17 **Highlighted Provisions:**
18 This bill:
19 ▸ prohibits balanced billing by certain health care providers in certain circumstances;
20 ▸ revises the basic benefit plan used for consumer comparison of health benefit
21 products;
22 ▸ requires the Insurance Department to include in its annual market report a summary
23 of the types of plans sold through the Internet portal, including market penetration
24 of mandate lite products;
25 ▸ allows insurers to offer lower cost health insurance products that do not include
26 certain state mandates in the individual market, the small employer group market,
27 and in the conversion market;
28 ▸ creates the Utah NetCare Plan, a low cost health benefit plan as an alternative to
29 current federal COBRA, state mini-COBRA, and conversion products;
30 ▸ requires health insurance brokers and producers to disclose their commissions and

31 compensation to their customers prior to selling a health benefit plan;
32 ▸ modifies the number and type of products an insurer must offer in the small
33 employer group market and the individual market;
34 ▸ establishes a defined contribution arrangement market available on the Internet
35 portal, which:
36 • beginning January 1, 2010, is available to small employer groups;
37 • offers a range of health benefit plan choices to an employer's eligible
38 employees;
39 • beginning January 1, 2012, is available to eligible large employer groups; and
40 • beginning January 1, 2012, will offer a wider range of choices of health benefit
41 plans to employees;
42 ▸ establishes a board within the Insurance Department that is given the responsibility
43 to develop a risk adjustment mechanism that will apportion risk among the insurers
44 participating in the Internet portal defined contribution market to protect insurers
45 from adverse risk selection;
46 ▸ requires insurers who offer health benefit plans on the Internet portal to provide
47 greater transparency and disclose information about the plan benefits, provider
48 networks, wellness programs, claim payment practices, and solvency ratings;
49 ▸ establishes a process for a consumer to compare health plan features on the Internet
50 portal and to enroll in a health benefit plan from the Internet portal;
51 ▸ requires the Office of Consumer Health Services to convene insurers and health
52 care providers to monitor and report to the Health Reform Task Force and to the
53 Business and Labor Interim Committee regarding progress towards expanding
54 access to the defined contribution market, greater choice in the market, and
55 payment reform demonstration projects;
56 ▸ establishes limited rulemaking authority for the Office of Consumer Health
57 Services to:
58 • assist employers and insurance carriers with interacting with the Internet portal;

59 and

60 • facilitate the receipt and payment of health plan premium payments from

61 multiple sources;

62 ▸ authorizes the Office of Consumer Health Services to establish a fee to cover the

63 transaction cost associated with the Internet portal functions such as sending and

64 processing an application or processing multiple premium payment sources; and

65 ▸ re-authorizes the Health Reform Task Force for one year.

66 **Monies Appropriated in this Bill:**

67 None

68 **Other Special Clauses:**

69 This bill provides an immediate effective date.

70 This bill repeals the Health Reform Task Force on December 30, 2009.

71 **Utah Code Sections Affected:**

72 AMENDS:

73 **31A-8-501**, as last amended by Laws of Utah 2004, Chapters 90, 229, and 367

74 **31A-22-613.5**, as last amended by Laws of Utah 2008, Chapters 241 and 345

75 **31A-22-617**, as last amended by Laws of Utah 2008, Chapter 3

76 **31A-22-722**, as last amended by Laws of Utah 2006, Chapter 188

77 **31A-22-723**, as last amended by Laws of Utah 2008, Chapters 241 and 250

78 **31A-23a-401**, as last amended by Laws of Utah 2007, Chapter 307

79 **31A-23a-501**, as renumbered and amended by Laws of Utah 2003, Chapter 298

80 **31A-30-102**, as last amended by Laws of Utah 2008, Chapter 345

81 **31A-30-103**, as last amended by Laws of Utah 2007, Chapter 307

82 **31A-30-104**, as last amended by Laws of Utah 2004, Chapter 108

83 **31A-30-107**, as last amended by Laws of Utah 2004, Chapter 329

84 **31A-30-109**, as last amended by Laws of Utah 1997, Chapter 265

85 **31A-30-112**, as last amended by Laws of Utah 2008, Chapter 345

86 **63M-1-2504**, as enacted by Laws of Utah 2008, Chapter 383

87 ENACTS:
88 **31A-22-618.5**, Utah Code Annotated 1953
89 **31A-22-724**, Utah Code Annotated 1953
90 **31A-30-201**, Utah Code Annotated 1953
91 **31A-30-202**, Utah Code Annotated 1953
92 **31A-30-203**, Utah Code Annotated 1953
93 **31A-30-204**, Utah Code Annotated 1953
94 **31A-30-205**, Utah Code Annotated 1953
95 **31A-30-206**, Utah Code Annotated 1953
96 **31A-30-207**, Utah Code Annotated 1953
97 **31A-30-208**, Utah Code Annotated 1953
98 **31A-42-101**, Utah Code Annotated 1953
99 **31A-42-102**, Utah Code Annotated 1953
100 **31A-42-103**, Utah Code Annotated 1953
101 **31A-42-201**, Utah Code Annotated 1953
102 **31A-42-202**, Utah Code Annotated 1953
103 **31A-42-203**, Utah Code Annotated 1953
104 **31A-42-204**, Utah Code Annotated 1953
105 **63M-1-2506**, Utah Code Annotated 1953
106 **Uncodified Material Affected:**
107 ENACTS UNCODIFIED MATERIAL
108

109 *Be it enacted by the Legislature of the state of Utah:*
110 Section 1. Section **31A-8-501** is amended to read:
111 **31A-8-501. Access to health care providers.**
112 (1) As used in this section:
113 (a) "Class of health care provider" means a health care provider or a health care
114 facility regulated by the state within the same professional, trade, occupational, or certification

115 category established under Title 58, Occupations and Professions, or within the same facility
116 licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and
117 Inspection Act.
118 (b) "Covered health care services" or "covered services" means health care services for
119 which an enrollee is entitled to receive under the terms of a health maintenance organization
120 contract.
121 (c) "Credentialed staff member" means a health care provider with active staff
122 privileges at an independent hospital or federally qualified health center.
123 (d) "Federally qualified health center" means as defined in the Social Security Act, 42
124 U.S.C. Sec. 1395x.
125 (e) "Independent hospital" means a general acute hospital or a critical access hospital
126 that:
127 (i) is either:
128 (A) located 20 miles or more from any other general acute hospital or critical access
129 hospital; or
130 (B) licensed as of January 1, 2004;
131 (ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and
132 Inspection Act; and
133 (iii) is controlled by a board of directors of which 51% or more reside in the county
134 where the hospital is located and:
135 (A) the board of directors is ultimately responsible for the policy and financial
136 decisions of the hospital; or
137 (B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part,
138 by an entity that owns or controls a health maintenance organization if the hospital is a
139 contracting facility of the organization.
140 (f) "Noncontracting provider" means an independent hospital, federally qualified
141 health center, or credentialed staff member who has not contracted with a health maintenance
142 organization to provide health care services to enrollees of the organization.

143 (2) Except for a health maintenance organization which is under the common
144 ownership or control of an entity with a hospital located within ten paved road miles of an
145 independent hospital, a health maintenance organization shall pay for covered health care
146 services rendered to an enrollee by an independent hospital, a credentialed staff member at an
147 independent hospital, or a credentialed staff member at his local practice location if:
148 (a) the enrollee:
149 (i) lives or resides within 30 paved road miles of the independent hospital; or
150 (ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the
151 independent hospital than a contracting hospital;
152 (b) the independent hospital is located prior to December 31, 2000 in a county with a
153 population density of less than 100 people per square mile, or the independent hospital is
154 located in a county with a population density of less than 30 people per square mile; and
155 (c) the enrollee has complied with the prior authorization and utilization review
156 requirements otherwise required by the health maintenance organization contract.
157 (3) A health maintenance organization shall pay for covered health care services
158 rendered to an enrollee at a federally qualified health center if:
159 (a) the enrollee:
160 (i) lives or resides within 30 paved road miles of the federally qualified health center;
161 or
162 (ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the
163 federally qualified health center than a contracting provider;
164 (b) the federally qualified health center is located in a county with a population density
165 of less than 30 people per square mile; and
166 (c) the enrollee has complied with the prior authorization and utilization review
167 requirements otherwise required by the health maintenance organization contract.
168 (4) (a) A health maintenance organization shall reimburse a noncontracting provider
169 or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as
170 it pays to contracting providers under a noncapitated arrangement for comparable services.

171 (b) A health maintenance organization shall reimburse a federally qualified health
172 center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as
173 paid by the health maintenance organization under a noncapitated arrangement for comparable
174 services to a contracting provider in the same class of health care providers as the provider
175 who rendered the service.
176 (5) (a) A noncontracting independent hospital may not balance bill a patient when the
177 health maintenance organization reimburses a noncontracting independent hospital or an
178 enrollee in accordance with Subsection (4)(a).
179 (b) A noncontracting federally qualified health center may not balance bill a patient
180 when the federally qualified health center or the enrollee receives reimbursement in
181 accordance with Subsection (4)(b).
182 [(5)] (6) A noncontracting provider may only refer an enrollee to another
183 noncontracting provider so as to obligate the enrollee's health maintenance organization to pay
184 for the resulting services if:
185 (a) the noncontracting provider making the referral or the enrollee has received prior
186 authorization from the organization for the referral; or
187 (b) the practice location of the noncontracting provider to whom the referral is made:
188 (i) is located in a county with a population density of less than 25 people per square
189 mile; and
190 (ii) is within 30 paved road miles of:
191 (A) the place where the enrollee lives or resides; or
192 (B) the independent hospital or federally qualified health center at which the enrollee
193 may receive covered services pursuant to Subsection (2) or (3).
194 [(6)] (7) Notwithstanding this section, a health maintenance organization may contract
195 directly with an independent hospital, federally qualified health center, or credentialed staff
196 member.
197 [(7)] (8) (a) A health maintenance organization that violates any provision of this
198 section is subject to sanctions as determined by the commissioner in accordance with Section

199 31A-2-308.

200 (b) Violations of this section include:

201 (i) failing to provide the notice required by Subsection [~~(7)~~] (8)(d) by placing the
202 notice in any health maintenance organization's provider list that is supplied to enrollees,
203 including any website maintained by the health maintenance organization;

204 (ii) failing to provide notice of an enrolles's rights under this section when:

205 (A) an enrollee makes personal contact with the health maintenance organization by
206 telephone, electronic transaction, or in person; and

207 (B) the enrollee inquires about his rights to access an independent hospital or federally
208 qualified health center; and

209 (iii) refusing to reprocess or reconsider a claim, initially denied by the health
210 maintenance organization, when the provisions of this section apply to the claim.

211 (c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of
212 Commissioner:

213 (i) adopt rules as necessary to implement this section;

214 (ii) identify in rule:

215 (A) the counties with a population density of less than 100 people per square mile;

216 (B) independent hospitals as defined in Subsection (1)(e); and

217 (C) federally qualified health centers as defined in Subsection (1)(d).

218 (d) (i) A health maintenance organization shall:

219 (A) use the information developed by the commissioner under Subsection [~~(7)~~] (8)(c)
220 to identify the rural counties, independent hospitals, and federally qualified health centers that
221 are located in the health maintenance organization's service area; and

222 (B) include the providers identified under Subsection [~~(7)~~] (8)(d)(i)(A) in the notice
223 required in Subsection [~~(7)~~] (8)(d)(ii).

224 (ii) The health maintenance organization shall provide the following notice, in bold
225 type, to enrollees as specified under Subsection [~~(7)~~] (8)(b)(i), and shall keep the notice
226 current:

227 "You may be entitled to coverage for health care services from the following non-HMO
228 contracted providers if you live or reside within 30 paved road miles of the listed providers, or
229 if you live or reside in closer proximity to the listed providers than to your HMO contracted
230 providers:
231 This list may change periodically, please check on our website or call for verification.
232 Please be advised that if you choose a noncontracted provider you will be responsible for any
233 charges not covered by your health insurance plan.
234 If you have questions concerning your rights to see a provider on this list you may
235 contact your health maintenance organization at ________. If the HMO does not resolve your
236 problem, you may contact the Office of Consumer Health Assistance in the Insurance
237 Department, toll free."
238 (e) A person whose interests are affected by an alleged violation of this section may
239 contact the Office of Consumer Health Assistance and request assistance, or file a complaint
240 as provided in Section 31A-2-216.
241 Section 2. Section **31A-22-613.5** is amended to read:
242 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**
243 **Care Plan.**
244 (1) (a) Except as provided in Subsection (1)(b), this section applies to all health
245 insurance policies and health maintenance organization contracts.
246 (b) Subsection [~~(3)~~] (2) applies to:
247 (i) all health insurance policies and health maintenance organization contracts; and
248 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
249 [~~(2) The commissioner shall adopt a Basic Health Care Plan consistent with this~~
250 ~~section to be offered under the open enrollment provisions of Chapter 30, Individual, Small~~
251 ~~Employer, and Group Health Insurance Act.~~]
252 [~~(3)~~] (2) (a) The commissioner shall promote informed consumer behavior and
253 responsible health insurance and health plans by requiring an insurer issuing health insurance
254 policies or health maintenance organization contracts to provide to all enrollees, prior to

255 enrollment in the health benefit plan or health insurance policy, written disclosure of:
256 (i) restrictions or limitations on prescription drugs and biologics including the use of a
257 formulary and generic substitution;
258 (ii) coverage limits under the plan; and
259 (iii) any limitation or exclusion of coverage including:
260 (A) a limitation or exclusion for a secondary medical condition related to a limitation
261 or exclusion from coverage; and
262 (B) beginning July 1, 2009, easily understood examples of a limitation or exclusion of
263 coverage for a secondary medical condition.
264 (b) In addition to the requirements of Subsections [~~(3)~~] (2)(a), (d), and (e) an insurer
265 described in Subsection [~~(3)~~] (2)(a) shall file the written disclosure required by this Subsection
266 [~~(3)~~] (2) to the commissioner:
267 (i) upon commencement of operations in the state; and
268 (ii) anytime the insurer amends any of the following described in Subsection [~~(3)(a)~~]
269 (2):
270 (A) treatment policies;
271 (B) practice standards;
272 (C) restrictions;
273 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
274 (E) limitations or exclusions of coverage including a limitation or exclusion for a
275 secondary medical condition related to a limitation or exclusion of the insurer's health
276 insurance plan.
277 (c) The commissioner may adopt rules to implement the disclosure requirements of
278 this Subsection [~~(3)~~] (2), taking into account:
279 (i) business confidentiality of the insurer;
280 (ii) definitions of terms;
281 (iii) the method of disclosure to enrollees; and
282 (iv) limitations and exclusions.

283 (d) If under Subsection [(3)] (2)(a)(i) a formulary is used, the insurer shall make
284 available to prospective enrollees and maintain evidence of the fact of the disclosure of:
285 (i) the drugs included;
286 (ii) the patented drugs not included;
287 (iii) any conditions that exist as a precedent to coverage; and
288 (iv) any exclusion from coverage for secondary medical conditions that may result
289 from the use of an excluded drug.
290 [~~(e) Before December 1, 2008, insurers subject to this Subsection (3) shall report to~~
291 ~~the Legislature's Health and Human Services Interim Committee and Business and Labor~~
292 ~~Interim Committee, either collectively or independently regarding insurer efforts to inform~~
293 ~~enrollees of any limitation of coverage or exclusion for a secondary medical condition when an~~
294 ~~enrollee, or someone on the enrollee's behalf, contacts the insurer for pre-authorization of a~~
295 ~~procedure or use of a drug that is excluded or limited from coverage.~~]
296 [~~(f)~~] (e) (i) The department shall develop examples of limitations or exclusions of a
297 secondary medical condition that an insurer may use under Subsection [~~(3)~~] (2)(a)(iii).
298 (ii) Examples of a limitation or exclusion of coverage provided under Subsection [~~(3)~~]
299 (2)(a)(iii) or otherwise are for illustrative purposes only, and the failure of a particular fact
300 situation to fall within the description of an example does not, by itself, support a finding of
301 coverage.
302 (3) An insurer who offers a health care plan under Chapter 30, Individual, Small
303 Employer, and Group Health Insurance Act, shall:
304 (a) until January 1, 2010, offer the basic health care plan described in Subsection (4)
305 subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and
306 Group Health Insurance Act; and
307 (b) beginning January 1, 2010, offer a basic health care plan subject to the open
308 enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance
309 Act, that:
310 (i) is a federally qualified high deductible health plan;

311 (ii) has the lowest deductible that qualifies under a federally qualified high deductible
312 health plan, as adjusted by federal law; and
313 (iii) does not exceed an annual out of pocket maximum equal to three times the
314 amount of the annual deductible.
315 (4) [The] Until January 1, 2010, the Basic Health Care Plan [adopted by the
316 commissioner] under this section shall provide for:
317 (a) a lifetime maximum benefit per person not [to exceed] less than $1,000,000;
318 (b) an annual maximum benefit per person not less than $250,000;
319 (c) an out-of-pocket maximum of cost-sharing features:
320 (i) including:
321 (A) a deductible;
322 (B) a copayment; and
323 (C) coinsurance;
324 (ii) not to exceed $5,000 per person; and
325 (iii) for family coverage, not to exceed three times the per person out-of-pocket
326 maximum provided in Subsection (4)(c)(ii);
327 (d) in relation to its cost-sharing features:
328 (i) a deductible of:
329 (A) not less than [$1,500] $1,000 per person for major medical expenses; and
330 (B) for family coverage, not to exceed three times the per person deductible for major
331 medical expenses under Subsection (4)(d)(i)(A); and
332 (ii) (A) a copayment of not less than:
333 (I) $25 per visit for office services; and
334 (II) $150 per visit to an emergency room; or
335 (B) coinsurance of not less than:
336 (I) 20% per visit for office services; and
337 (II) 20% per visit for an emergency room; and
338 (e) in relation to cost-sharing features for prescription drugs:

339 (i) (A) a deductible not to exceed $1,000 per person; and
340 (B) for family coverage, not to exceed three times the per person deductible provided
341 in Subsection (4)(e)(i)(A); and
342 (ii) (A) a copayment of not less than:
343 (I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for
344 prescription drugs;
345 (II) the lesser of the cost of the prescription drug or $25 for the second level of cost for
346 prescription drugs; and
347 (III) the lesser of the cost of the prescription drug or $35 for the highest level of cost
348 for prescription drugs; or
349 (B) coinsurance of not less than:
350 (I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for
351 prescription drugs;
352 (II) the lesser of the cost of the prescription drug or 40% for the second level of cost
353 for prescription drugs; and
354 (III) the lesser of the cost of the prescription drug or 60% for the highest level of cost
355 for prescription drugs.
356 (5) The department shall include in its yearly insurance market report information
357 about:
358 (a) the types of health benefit plans sold on the Internet portal created in Section
359 63M-1-2504;
360 (b) the number of insurers participating in the defined contribution market on the
361 Internet portal;
362 (c) the number of employers and covered lives in the defined contribution market; and
363 (d) the number of lives covered by health benefit plans that do not include state
364 mandates as permitted by Subsection 31A-30-109(2).
365 (6) The commissioner may request information from an insurer to verify the
366 information submitted by the insurer to the Internet portal under Subsection 63M-1-2506(4).

367 Section 3. Section **31A-22-617** is amended to read:

368 **31A-22-617. Preferred provider contract provisions.**

369 Health insurance policies may provide for insureds to receive services or
370 reimbursement under the policies in accordance with preferred health care provider contracts
371 as follows:

372 (1) Subject to restrictions under this section, any insurer or third party administrator
373 may enter into contracts with health care providers as defined in Section 78B-3-403 under
374 which the health care providers agree to supply services, at prices specified in the contracts, to
375 persons insured by an insurer.

376 (a) (i) A health care provider contract may require the health care provider to accept
377 the specified payment as payment in full, relinquishing the right to collect additional amounts
378 from the insured person.

379 (ii) In any dispute involving a provider's claim for reimbursement, the same shall be
380 determined in accordance with applicable law, the provider contract, the subscriber contract,
381 and the insurer's written payment policies in effect at the time services were rendered.

382 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to
383 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense
384 except the cost of the jointly selected arbitrator shall be equally shared. This Subsection
385 (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent
386 with the hospital's provider agreement.

387 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
388 or otherwise demanding payment for a sum believed owing.

389 (v) If an insurer permits another entity with which it does not share common
390 ownership or control to use or otherwise lease one or more of the organization's networks of
391 participating providers, the organization shall ensure, at a minimum, that the entity pays
392 participating providers in accordance with the same fee schedule and general payment policies
393 as the organization would for that network.

394 (b) The insurance contract may reward the insured for selection of preferred health

395 care providers by:
396 (i) reducing premium rates;
397 (ii) reducing deductibles;
398 (iii) coinsurance;
399 (iv) other copayments; or
400 (v) any other reasonable manner.
401 (c) If the insurer is a managed care organization, as defined in Subsection
402 31A-27a-403(1)(f):
403 (i) the insurance contract and the health care provider contract shall provide that in the
404 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
405 (A) require the health care provider to continue to provide health care services under
406 the contract until the earlier of:
407 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
408 liquidation; or
409 (II) the date the term of the contract ends; and
410 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
411 receive from the managed care organization during the time period described in Subsection
412 (1)(c)(i)(A);
413 (ii) the provider is required to:
414 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
415 (B) relinquish the right to collect additional amounts from the insolvent managed care
416 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
417 (iii) if the contract between the health care provider and the managed care
418 organization has not been reduced to writing, or the contract fails to contain the language
419 required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the
420 enrollee:
421 (A) sums owed by the insolvent managed care organization; or
422 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

423 (iv) the following may not bill or maintain any action at law against an enrollee to
424 collect sums owed by the insolvent managed care organization or the amount of the regular fee
425 reduction authorized under Subsection (1)(c)(i)(B):
426 (A) a provider;
427 (B) an agent;
428 (C) a trustee; or
429 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
430 (v) notwithstanding Subsection (1)(c)(i):
431 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the
432 provider's regular fee set forth in the contract; and
433 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
434 for services received from the provider that the enrollee was required to pay before the filing
435 of:
436 (I) a petition for rehabilitation; or
437 (II) a petition for liquidation.
438 (2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health
439 care provider contracts shall pay for the services of health care providers not under the
440 contract, unless the illnesses or injuries treated by the health care provider are not within the
441 scope of the insurance contract. As used in this section, "class of health care providers" means
442 all health care providers licensed or licensed and certified by the state within the same
443 professional, trade, occupational, or facility licensure or licensure and certification category
444 established pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions.
445 (b) [~~When~~] (i) Until July 1, 2012, when the insured receives services from a health
446 care provider not under contract, the insurer shall reimburse the insured for at least 75% of the
447 average amount paid by the insurer for comparable services of preferred health care providers
448 who are members of the same class of health care providers.
449 (ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that
450 complies with the provisions of Subsection 31A-22-618.5(3).

451 (iii) The commissioner may adopt a rule dealing with the determination of what
452 constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for
453 comparable services of preferred health care providers who are members of the same class of
454 health care providers.
455 (c) When reimbursing for services of health care providers not under contract, the
456 insurer may make direct payment to the insured.
457 (d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider
458 contracts may impose a deductible on coverage of health care providers not under contract.
459 (e) When selecting health care providers with whom to contract under Subsection (1),
460 an insurer may not unfairly discriminate between classes of health care providers, but may
461 discriminate within a class of health care providers, subject to Subsection (7).
462 (f) For purposes of this section, unfair discrimination between classes of health care
463 providers shall include:
464 (i) refusal to contract with class members in reasonable proportion to the number of
465 insureds covered by the insurer and the expected demand for services from class members; and
466 (ii) refusal to cover procedures for one class of providers that are:
467 (A) commonly utilized by members of the class of health care providers for the
468 treatment of illnesses, injuries, or conditions;
469 (B) otherwise covered by the insurer; and
470 (C) within the scope of practice of the class of health care providers.
471 (3) Before the insured consents to the insurance contract, the insurer shall fully
472 disclose to the insured that it has entered into preferred health care provider contracts. The
473 insurer shall provide sufficient detail on the preferred health care provider contracts to permit
474 the insured to agree to the terms of the insurance contract. The insurer shall provide at least
475 the following information:
476 (a) a list of the health care providers under contract and if requested their business
477 locations and specialties;
478 (b) a description of the insured benefits, including any deductibles, coinsurance, or

479 other copayments;
480 (c) a description of the quality assurance program required under Subsection (4); and
481 (d) a description of the adverse benefit determination procedures required under
482 Subsection (5).
483 (4) (a) An insurer using preferred health care provider contracts shall maintain a
484 quality assurance program for assuring that the care provided by the health care providers
485 under contract meets prevailing standards in the state.
486 (b) The commissioner in consultation with the executive director of the Department of
487 Health may designate qualified persons to perform an audit of the quality assurance program.
488 The auditors shall have full access to all records of the organization and its health care
489 providers, including medical records of individual patients.
490 (c) The information contained in the medical records of individual patients shall
491 remain confidential. All information, interviews, reports, statements, memoranda, or other
492 data furnished for purposes of the audit and any findings or conclusions of the auditors are
493 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
494 proceeding except hearings before the commissioner concerning alleged violations of this
495 section.
496 (5) An insurer using preferred health care provider contracts shall provide a reasonable
497 procedure for resolving complaints and adverse benefit determinations initiated by the
498 insureds and health care providers.
499 (6) An insurer may not contract with a health care provider for treatment of illness or
500 injury unless the health care provider is licensed to perform that treatment.
501 (7) (a) A health care provider or insurer may not discriminate against a preferred
502 health care provider for agreeing to a contract under Subsection (1).
503 (b) Any health care provider licensed to treat any illness or injury within the scope of
504 the health care provider's practice, who is willing and able to meet the terms and conditions
505 established by the insurer for designation as a preferred health care provider, shall be able to
506 apply for and receive the designation as a preferred health care provider. Contract terms and

507 conditions may include reasonable limitations on the number of designated preferred health
508 care providers based upon substantial objective and economic grounds, or expected use of
509 particular services based upon prior provider-patient profiles.
510 (8) Upon the written request of a provider excluded from a provider contract, the
511 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
512 based on the criteria set forth in Subsection (7)(b).
513 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5,
514 and 31A-22-618.
515 (10) Nothing in this section is to be construed as to require an insurer to offer a certain
516 benefit or service as part of a health benefit plan.
517 (11) This section does not apply to catastrophic mental health coverage provided in
518 accordance with Section 31A-22-625.
519 Section 4. Section **31A-22-618.5** is enacted to read:
520 **31A-22-618.5. Health plan offerings.**
521 (1) The purpose of this section is to increase the range of health benefit plans available
522 in the small group, small employer group, large group, and individual insurance markets.
523 (2) A health maintenance organization that is subject to Chapter 8, Health
524 Maintenance Organizations and Limited Health Plans:
525 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
526 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
527 and
528 (b) may offer to a potential purchaser one or more health benefit plans that:
529 (i) are not subject to one or more of the following:
530 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
531 (B) the limitation on point of service products in Subsections 31A-8-408(3) through
532 (6);
533 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
534 Section 31A-8-101; or

535 (D) coverage mandates enacted after January 1, 2009 that are not required by federal
536 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
537 enacted after January 1, 2009; and
538 (ii) when offering a health plan under this section, provide coverage for an emergency
539 medical condition as required by Section 31A-22-627 as follows:
540 (A) within the organization's service area, covered services shall include health care
541 services from non-affiliated providers when medically necessary to stabilize an emergency
542 medical condition; and
543 (B) outside the organization's service area, covered services shall include medically
544 necessary health care services for the treatment of an emergency medical condition that are
545 immediately required while the enrollee is outside the geographic limits of the organization's
546 service area.
547 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
548 Maintenance Organizations and Limited Health Plans:
549 (a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that
550 groups providers into the following reimbursement levels:
551 (i) tier one contracted providers;
552 (ii) tier two contracted providers who the insurer must reimburse at least 75% of tier
553 one providers; and
554 (iii) one or more tiers of non-contracted providers; and
555 (b) may offer a health benefit plan that is not subject to Subsection 31A-22-617(9) and
556 Section 31A-22-618;
557 (c) beginning July 1, 2012, may offer products under Subsection (3)(a) that:
558 (i) are not subject to Subsection 31A-22-617(2); and
559 (ii) are subject to the reimbursement requirements in Section 31A-8-501;
560 (d) when offering a health plan under this Subsection (3), shall provide coverage of
561 emergency care services as required by Section 31A-22-627 by providing coverage at a
562 reimbursement level of at least 75% of tier one providers; and

563 (e) are not subject to coverage mandates enacted after January 1, 2009 that are not
564 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
565 after January 1, 2009.
566 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
567 Subsection (2)(b).
568 (5) (a) Any difference in price between a health benefit plan offered under Subsections
569 (2)(a) and (b) shall be based on actuarially sound data.
570 (b) Any difference in price between a health benefit plan offered under Subsections
571 (3)(a) and (b) shall be based on actuarially sound data.
572 (6) Nothing in this section limits the number of health benefit plans that an insurer
573 may offer.
574 Section 5. Section **31A-22-722** is amended to read:
575 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**
576 (1) An insured has the right to extend the employee's coverage under the current
577 employer's group policy for a period of [~~six~~] 12 months, except as provided in Subsection (2).
578 The right to extend coverage includes:
579 (a) voluntary termination;
580 (b) involuntary termination;
581 (c) retirement;
582 (d) death;
583 (e) divorce or legal separation;
584 (f) loss of dependent status;
585 (g) sabbatical;
586 (h) any disability;
587 (i) leave of absence; or
588 (j) reduction of hours.
589 (2) (a) Notwithstanding the provisions of Subsection (1), an employee does not have
590 the right to extend coverage under the current employer's group policy if the employee:

591 (i) failed to pay any required individual contribution;
592 (ii) acquires other group coverage covering all preexisting conditions including
593 maternity, if the coverage exists;
594 (iii) performed an act or practice that constitutes fraud in connection with the
595 coverage;
596 (iv) made an intentional misrepresentation of material fact under the terms of the
597 coverage;
598 (v) was terminated for gross misconduct;
599 (vi) has not been continuously covered under the current employer's group policy for a
600 period of [~~six~~] three months immediately prior to the termination of the policy due to the
601 events set forth in Subsection (1); [~~or~~]
602 (vii) is eligible for any extension of coverage required by federal law[~~.~~]; or
603 (viii) elected alternative coverage under Section 31A-22-724.
604 (b) The right to extend coverage under Subsection (1) applies to any spouse or
605 dependent coverages, including a surviving spouse or dependents whose coverage under the
606 policy terminates by reason of the death of the employee or member.
607 (3) (a) The employer shall provide written notification of the right to extend group
608 coverage and the payment amounts required for extension of coverage, including the manner,
609 place, and time in which the payments shall be made to:
610 (i) the terminated insured;
611 (ii) the ex-spouse; or
612 (iii) if Subsection (2)(b) applies:
613 (A) to a surviving spouse; and
614 (B) the guardian of surviving dependents, if different from a surviving spouse.
615 (b) The notification shall be sent first class mail within 30 days after the termination
616 date of the group coverage to:
617 (i) the terminated insured's home address as shown on the records of the employer;
618 (ii) the address of the surviving spouse, if different from the insured's address and if

619 shown on the records of the employer;
620 (iii) the guardian of any dependents address, if different from the insured's address,
621 and if shown on the records of the employer; and
622 (iv) the address of the ex-spouse, if shown on the records of the employer.
623 (4) The insurer shall provide the employee, spouse, or any eligible dependent the
624 opportunity to extend the group coverage at the payment amount stated in [~~this~~] Subsection
625 [~~(3)~~] (5) if:
626 (a) the employer policyholder does not provide the terminated insured the written
627 notification required by Subsection (3)(a); and
628 (b) the employee or other individual eligible for extension contacts the insurer within
629 60 days of coverage termination.
630 (5) The premium amount for extended group coverage may not exceed 102% of the
631 group rate in effect for a group member, including an employer's contribution, if any, for a
632 group insurance policy.
633 (6) Except as provided in this Subsection (6), the coverage extends without
634 interruption for [~~six~~] 12 months and may not terminate if the terminated insured or, with
635 respect to a minor, the parent or guardian of the terminated insured:
636 (a) elects to extend group coverage within 60 days of losing group coverage; and
637 (b) tenders the amount required to the employer or insurer.
638 (7) The insured's coverage may be terminated prior to [~~six~~] 12 months if the
639 terminated insured:
640 (a) establishes residence outside of this state;
641 (b) moves out of the insurer's service area;
642 (c) fails to pay premiums or contributions in accordance with the terms of the policy,
643 including any timeliness requirements;
644 (d) performs an act or practice that constitutes fraud in connection with the coverage;
645 (e) makes an intentional misrepresentation of material fact under the terms of the
646 coverage;

647 (f) becomes eligible for similar coverage under another group policy; or
648 (g) employer's coverage is terminated, except as provided in Subsection (8).
649 (8) If the current employer coverage is terminated and the employer replaces coverage
650 with similar coverage under another group policy, without interruption, the terminated insured,
651 spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have
652 the right to obtain extension of coverage under the replacement group policy:
653 (a) for the balance of the period the terminated insured would have extended coverage
654 under the replaced group policy; and
655 (b) if the terminated insured is otherwise eligible for extension of coverage.
656 (9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the
657 employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of
658 the insured, the surviving spouse, or guardian of any dependents, written notification of the
659 right to an individual conversion policy under Section 31A-22-723.
660 (b) The notification required by Subsection (9)(a):
661 (i) shall be sent first class mail to:
662 (A) the insured's last-known address as shown on the records of the employer;
663 (B) the address of the surviving spouse, if different from the insured's address, and if
664 shown on the records of the employer;
665 (C) the guardian of any dependents last known address as shown on the records of the
666 employer, if different from the address of the surviving spouse; and
667 (D) the address of the ex-spouse as shown on the records of the employer, if
668 applicable; and
669 (ii) shall contain the name, address, and telephone number of the insurer that will
670 provide the conversion coverage.
671 Section 6. Section **31A-22-723** is amended to read:
672 **31A-22-723. Group and blanket conversion coverage.**
673 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in
674 Subsection (3), all policies of accident and health insurance offered on a group basis under

675 this title, or Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall
676 provide that a person whose insurance under the group policy has been terminated is entitled
677 to choose a converted individual policy [~~of similar accident and health insurance~~] in
678 accordance with this section and Section 31A-22-724.
679 (2) A person who has lost group coverage may elect conversion coverage with the
680 insurer that provided prior group coverage if the person:
681 (a) has been continuously covered for a period of [~~six~~] three months by the group
682 policy or the group's preceding policies immediately prior to termination;
683 (b) has exhausted either:
684 (i) Utah mini-COBRA coverage as required in Section 31A-22-722 [~~or~~];
685 (ii) federal COBRA coverage; or
686 (iii) alternative coverage under Section 31A-22-724;
687 (c) has not acquired or is not covered under any other group coverage that covers all
688 preexisting conditions, including maternity, if the coverage exists; and
689 (d) resides in the insurer's service area.
690 (3) This section does not apply if the person's prior group coverage:
691 (a) is a stand alone policy that only provides one of the following:
692 (i) catastrophic benefits;
693 (ii) aggregate stop loss benefits;
694 (iii) specific stop loss benefits;
695 (iv) benefits for specific diseases;
696 (v) accidental injuries only;
697 (vi) dental; or
698 (vii) vision;
699 (b) is an income replacement policy;
700 (c) was terminated because the insured:
701 (i) failed to pay any required individual contribution;
702 (ii) performed an act or practice that constitutes fraud in connection with the coverage;

703 or

704 (iii) made intentional misrepresentation of material fact under the terms of coverage;

705 or

706 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or

707 31A-30-107(2)(a).

708 (4) (a) The employer shall provide written notification of the right to an individual

709 conversion policy within 30 days of the insured's termination of coverage to:

710 (i) the terminated insured;

711 (ii) the ex-spouse; or

712 (iii) in the case of the death of the insured:

713 (A) the surviving spouse; and

714 (B) the guardian of any dependents, if different from a surviving spouse.

715 (b) The notification required by Subsection (4)(a) shall:

716 (i) be sent by first class mail;

717 (ii) contain the name, address, and telephone number of the insurer that will provide

718 the conversion coverage; and

719 (iii) be sent to the insured's last-known address as shown on the records of the

720 employer of:

721 (A) the insured;

722 (B) the ex-spouse; and

723 (C) if the policy terminates by reason of the death of the insured to:

724 (I) the surviving spouse; and

725 (II) the guardian of any dependents, if different from a surviving spouse.

726 (5) (a) An insurer is not required to issue a converted policy which provides benefits

727 in excess of those provided under the group policy from which conversion is made.

728 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health

729 benefit plan, the employee or member [~~must~~] shall be offered:

730 (i) at least the basic benefit plan as provided in Section 31A-22-613.5 through

731 December 31, 2009; and

732 (ii) beginning January 1, 2010, only the alternative coverage as provided in Subsection

733 31A-22-724(1)(a).

734 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels

735 provided under the group policy, the conversion policy may offer benefits which are

736 substantially similar to those provided under the group policy.

737 (6) Written application for the converted policy shall be made and the first premium

738 paid to the insurer no later than 60 days after termination of the group accident and health

739 insurance.

740 (7) The converted policy shall be issued without evidence of insurability.

741 (8) (a) The initial premium for the converted policy for the first 12 months and

742 subsequent renewal premiums shall be determined in accordance with premium rates

743 applicable to age, class of risk of the person, and the type and amount of insurance provided.

744 (b) The initial premium for the first 12 months may not be raised based on pregnancy

745 of a covered insured.

746 (c) The premium for converted policies shall be payable monthly or quarterly as

747 required by the insurer for the policy form and plan selected, unless another mode or premium

748 payment is mutually agreed upon.

749 (9) The converted policy becomes effective at the time the insurance under the group

750 policy terminates.

751 (10) (a) A newly issued converted policy covers the employee or the member and must

752 also cover all dependents covered by the group policy at the date of termination of the group

753 coverage.

754 (b) The only dependents that may be added after the policy has been issued are

755 children and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6)

756 and (7).

757 (c) At the option of the insurer, a separate converted policy may be issued to cover any

758 dependent.

759 (11) (a) To the extent the group policy provided maternity benefits, the conversion
760 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group
761 policy or the conversion policy until termination of a pregnancy that exists on the date of
762 conversion if one of the following is pregnant on the date of the conversion:
763 (i) the insured;
764 (ii) a spouse of the insured; or
765 (iii) a dependent of the insured.
766 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs
767 after the date of conversion.
768 (12) Except as provided in this Subsection (12), a converted policy is renewable with
769 respect to all individuals or dependents at the option of the insured. An insured may be
770 terminated from a converted policy for the following reasons:
771 (a) a dependent is no longer eligible under the policy;
772 (b) for a network plan, if the individual no longer lives, resides, or works in:
773 (i) the insured's service area; or
774 (ii) the area for which the covered carrier is authorized to do business;
775 (c) the individual fails to pay premiums or contributions in accordance with the terms
776 of the converted policy, including any timeliness requirements;
777 (d) the individual performs an act or practice that constitutes fraud in connection with
778 the coverage;
779 (e) the individual makes an intentional misrepresentation of material fact under the
780 terms of the coverage; or
781 (f) coverage is terminated uniformly without regard to any health status-related factor
782 relating to any covered individual.
783 (13) Conditions pertaining to health may not be used as a basis for classification under
784 this section.
785 Section 7. Section **31A-22-724** is enacted to read:
786 **31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**

787 (1) For purposes of this section, "alternative coverage" means:
788 (a) the high deductible or low deductible Utah NetCare Plan described in Subsection
789 (2) for conversion policies offered under Section 31A-22-723; and
790 (b) the high deductible and low deductible Utah NetCare Plans described in
791 Subsection (2) as an alternative to COBRA and mini-COBRA policies offered under Section
792 31A-22-722.
793 (2) The Utah NetCare Plans shall include:
794 (a) healthy lifestyle and wellness incentives;
795 (b) the benefits described in this Subsection (2) or at least the actuarial equivalent of
796 the benefits described in this Subsection (2);
797 (c) a lifetime maximum benefit per person of not less than $1,000,000;
798 (d) an annual maximum benefit per person of not less than $250,000;
799 (e) the following deductibles:
800 (i) for the low deductible plans:
801 (A) $2,000 for an individual plan;
802 (B) $4,000 for a two party plan; and
803 (C) $6,000 for a family plan;
804 (ii) for the high deductible plans:
805 (A) $4,000 for an individual plan;
806 (B) $8,000 for a two party plan; and
807 (C) $12,000 for a family plan;
808 (f) the following out-of-pocket maximum costs, including deductibles, copayments,
809 and coinsurance:
810 (i) for the low deductible plans:
811 (A) $5,000 for an individual plan;
812 (B) $10,000 for a two party plan; and
813 (C) $15,000 for a family plan; and
814 (ii) for the high deductible plan:

815 (A) $10,000 for an individual plan;
816 (B) $20,000 for a two party plan; and
817 (C) $30,000 for a family plan;
818 (g) the following benefits before applying any deductible requirements and in
819 accordance with IRC Section 223:
820 (i) all well child exams and immunizations up to age five, with no annual maximum;
821 (ii) preventive care up to a $500 annual maximum;
822 (iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i)
823 or (ii) up to a $300 annual maximum; and
824 (iv) supplemental accident coverage up to a $500 annual maximum;
825 (h) the following copayments for each exam:
826 (i) $15 for preventive care and well child exams;
827 (ii) $25 for primary care; and
828 (iii) $50 for urgent care and specialist care;
829 (i) a $200 copayment for emergency room visits after applying the deductible;
830 (j) no more than a 30% coinsurance after deductible for covered plan benefits for
831 hospital services, maternity, laboratory work, x-rays, radiology, outpatient surgery services,
832 injectable medications not otherwise covered under a pharmacy benefit, durable medical
833 equipment, ambulance services, in-patient mental health services, and out-patient mental
834 health services; and
835 (k) the following cost-sharing features for prescription drugs:
836 (i) up to a $15 copayment for generic drugs;
837 (ii) up to a 50% coinsurance for name brand drugs; and
838 (iii) may include formularies and preferred drug lists.
839 (3) The Utah NetCare Plans may exclude:
840 (a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and
841 (b) unless required by federal law, mandated coverage required by the following
842 sections and related administrative rules:

843 (i) Section 31A-22-610.1, Adoption indemnity benefits;
844 (ii) Section 31A-22-623, Inborn metabolic errors;
845 (iii) Section 31A-22-624, Primary care physicians;
846 (iv) Section 31A-22-626, Coverage of diabetes;
847 (v) Section 31A-22-628, Standing referral to a specialist; and
848 (vi) coverage mandates enacted after January 1, 2009 that are not required by federal
849 law.
850 (4) (a) Beginning January 1, 2010, and except as provided in Subsection (5), a person
851 may elect alternative coverage under this section if the person:
852 (i) is eligible for continuation of employer group coverage under federal COBRA
853 laws;
854 (ii) is eligible for continuation of employer group coverage under state mini-COBRA
855 under Section 31A-22-722; or
856 (iii) is eligible for a conversion to an individual plan after the exhaustion of benefits
857 under:
858 (A) alternative coverage elected in place of federal COBRA; or
859 (B) state mini-COBRA under Section 31A-22-722.
860 (b) The right to extend coverage under Subsection (4)(a) applies to any spouse or
861 dependent coverages, including a surviving spouse or dependent whose coverage under the
862 policy terminates by reason of the death of the employee or member.
863 (5) If a person elects federal COBRA coverage, or state mini-COBRA coverage under
864 Section 31A-22-722, the person is not eligible to elect alternative coverage under this section
865 until the person is eligible to convert coverage to an individual policy under the provisions of
866 Section 31A-22-723 and Subsection (1)(a).
867 (6) (a) If the alternative coverage is selected as an alternative to COBRA or
868 mini-COBRA under Section 31A-22-722, the provisions of Section 31A-22-722 apply to the
869 alternative coverage.
870 (b) If the alternative coverage is selected as a conversion policy under Section

871 31A-22-723, the provisions of Section 31A-22-723 apply.
872 (7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to
873 September 1, 2009, file an alternative coverage policy with the department in accordance with
874 Sections 31A-21-201 and 31A-21-201.1.
875 (b) The department shall, by November 1, 2009, adopt administrative rules in
876 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to develop a
877 model letter for employers to use to notify an employee of the employee's options for
878 alternative coverage.
879 Section 8. Section **31A-23a-401** is amended to read:
880 **31A-23a-401. Disclosure of conflicting interests.**
881 (1) (a) Except as provided under Subsection (1)(b):
882 (i) a licensee under this chapter may not act in the same or any directly related
883 transaction as:
884 (A) a producer for the insured or consultant; and
885 (B) producer for the insurer; and
886 (ii) a producer for the insured or consultant may not recommend or encourage the
887 purchase of insurance from or through an insurer or other producer:
888 (A) of which the producer for the insured or consultant or producer for the insured's or
889 consultant's spouse is an owner, executive, or employee; or
890 (B) to which the producer for the insured or consultant has the type of relation that a
891 material benefit would accrue to the producer for the insured or consultant or spouse as a
892 result of the purchase.
893 (b) Subsection (1)(a) does not apply if the following three conditions are met:
894 (i) Prior to performing the consulting services, the producer for the insured or
895 consultant shall disclose to the client, prominently, in writing:
896 (A) the producer for the insured's or consultant's interest as a producer for the insurer,
897 or the relationship to an insurer or other producer; and
898 (B) that as a result of those interests, the producer for the insured's or the consultant's

899 recommendations should be given appropriate scrutiny.

900 (ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing,
901 after the disclosure required under Subsection (1)(b)(i), but before performing the requested
902 services.

903 (iii) Any report resulting from requested services shall contain a copy of the disclosure
904 made under Subsection (1)(b)(i).

905 (2) A licensee under this chapter may not act as to the same client as both a producer
906 for the insurer and a producer for the insured without the client's prior written consent based
907 on full disclosure.

908 (3) Whenever a person applies for insurance coverage through a producer for the
909 insured, the producer for the insured shall disclose to the applicant, in writing, that the
910 producer for the insured is not the producer for the insurer or the potential insurer. This
911 disclosure shall also inform the applicant that the applicant likely does not have the benefit of
912 an insurer being financially responsible for the conduct of the producer for the insured.

913 (4) If a licensee is subject to both this section and Subsection 31A-23a-501(4), the
914 licensee shall provide the disclosure required under each statute.

915 Section 9. Section **31A-23a-501** is amended to read:

916 **31A-23a-501. Licensee compensation.**

917 (1) As used in this section:

918 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
919 licensee from:

920 (i) commission amounts deducted from insurance premiums on insurance sold by or
921 placed through the licensee; or

922 (ii) commission amounts received from an insurer or another licensee as a result of the
923 sale or placement of insurance.

924 (b) (i) "Compensation from an insurer or third party administrator" means
925 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
926 gifts, prizes, or any other form of valuable consideration:

927 (A) whether or not payable pursuant to a written agreement; and
928 (B) received from:
929 (I) an insurer; or
930 (II) a third party to the transaction for the sale or placement of insurance.
931 (ii) "Compensation from an insurer or third party administrator" does not mean
932 compensation from a customer that is:
933 (A) a fee or pass-through costs as provided in Subsection (1)(e); or
934 (B) a fee or amount collected by or paid to the producer that does not exceed an
935 amount established by the commissioner by administrative rule.
936 (c) (i) "Customer" means:
937 (A) the person signing the application or submission for insurance; or
938 (B) the authorized representative of the insured actually negotiating the placement of
939 insurance with the producer.
940 (ii) "Customer" does not mean a person who is a participant or beneficiary of:
941 (A) an employee benefit plan; or
942 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
943 negotiated by the producer or affiliate.
944 [(b)] (d) (i) "Noncommission compensation" includes all funds paid to or credited for
945 the benefit of a licensee other than commission compensation.
946 (ii) "Noncommission compensation" does not include charges for pass-through costs
947 incurred by the licensee in connection with obtaining, placing, or servicing an insurance
948 policy.
949 [(c)] (e) "Pass-through costs" include:
950 (i) costs for copying documents to be submitted to the insurer; and
951 (ii) bank costs for processing cash or credit card payments.
952 (2) A licensee may receive from an insured or from a person purchasing an insurance
953 policy, noncommission compensation if the noncommission compensation is stated on a
954 separate, written disclosure.

955 (a) The disclosure required by this Subsection (2) shall:
956 (i) include the signature of the insured or prospective insured acknowledging the
957 noncommission compensation;
958 (ii) clearly specify the amount or extent of the noncommission compensation; and
959 (iii) be provided to the insured or prospective insured before the performance of the
960 service.
961 (b) Noncommission compensation shall be:
962 (i) limited to actual or reasonable expenses incurred for services; and
963 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
964 business or for a specific service or services.
965 (c) A copy of the signed disclosure required by this Subsection (2) must be maintained
966 by any licensee who collects or receives the noncommission compensation or any portion
967 [~~thereof~~] of the noncommission compensation.
968 (d) All accounting records relating to noncommission compensation shall be
969 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.
970 (3) (a) A licensee may receive noncommission compensation when acting as a
971 producer for the insured in connection with the actual sale or placement of insurance if:
972 (i) the producer and the insured have agreed on the producer's noncommission
973 compensation; and
974 (ii) the producer has disclosed to the insured the existence and source of any other
975 compensation that accrues to the producer as a result of the transaction.
976 (b) The disclosure required by this Subsection (3) shall:
977 (i) include the signature of the insured or prospective insured acknowledging the
978 noncommission compensation;
979 (ii) clearly specify the amount or extent of the noncommission compensation and the
980 existence and source of any other compensation; and
981 (iii) be provided to the insured or prospective insured before the performance of the
982 service.

983 (c) The following additional noncommission compensation is authorized:
984 (i) compensation received by a producer of a compensated corporate surety who under
985 procedures approved by a rule or order of the commissioner is paid by surety bond principal
986 debtors for extra services;
987 (ii) compensation received by an insurance producer who is also licensed as a public
988 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
989 claim adjustment, so long as the producer does not receive or is not promised compensation
990 for aiding in the claim adjustment prior to the occurrence of the claim;
991 (iii) compensation received by a consultant as a consulting fee, provided the
992 consultant complies with the requirements of Section 31A-23a-401; or
993 (iv) other compensation arrangements approved by the commissioner after a finding
994 that they do not violate Section 31A-23a-401 and are not harmful to the public.
995 (4) (a) For purposes of this Subsection (4), "producer" includes:
996 (i) a producer;
997 (ii) an affiliate of a producer; or
998 (iii) a consultant.
999 (b) Beginning January 1, 2010, in addition to any other disclosures required by this
1000 section, a producer may not accept or receive any compensation from an insurer or third party
1001 administrator for the placement of a health benefit plan, other than a hospital confinement
1002 indemnity policy, unless prior to the customer's purchase of the health benefit plan the
1003 producer:
1004 (i) except as provided in Subsection (4)(c), discloses in writing to the customer that
1005 the producer will receive compensation from the insurer or third party administrator for the
1006 placement of insurance, including the amount or type of compensation known to the producer
1007 at the time of the disclosure; and
1008 (ii) except as provided in Subsection (4)(c):
1009 (A) obtains the customer's signed acknowledgment that the disclosure under
1010 Subsection (4)(b)(i) was made to the customer; or

1011 (B) certifies to the insurer that the disclosure required by Subsection (4)(b)(i) was
1012 made to the customer.
1013 (c) If the compensation to the producer from an insurer or third party administrator is
1014 for the renewal of health care insurance, once the producer has made an initial disclosure that
1015 complies with Subsection (4)(b), the producer does not have to disclose compensation
1016 received for the subsequent yearly renewals in accordance with Subsection (4)(b) until the
1017 renewal period immediately following 36 months after the initial disclosure.
1018 (d) (i) A copy of the signed acknowledgment required by Subsection (4)(b) must be
1019 maintained by the licensee who collects or receives any part of the compensation from an
1020 insurer or third party administrator in a manner that facilitates an audit.
1021 (ii) The standard application developed in accordance with Section 31A-22-635 shall
1022 include a place for a producer to provide the disclosure required by Subsection (4), and if
1023 completed, shall satisfy the requirement of Subsection (4)(d)(i).
1024 (e) Subsection (4)(b)(ii) does not apply to:
1025 (i) a person licensed as a producer who acts only as an intermediary between an
1026 insurer and the customer's producer, including a managing general agent; or
1027 (ii) the placement of insurance in a secondary or residual market.
1028 [~~(4)~~] (5) This section does not alter the right of any licensee to recover from an insured
1029 the amount of any premium due for insurance effected by or through that licensee or to charge
1030 a reasonable rate of interest upon past-due accounts.
1031 [~~(5)~~] (6) This section does not apply to bail bond producers or bail enforcement agents
1032 as defined in Section 31A-35-102.
1033 Section 10. Section **31A-30-102** is amended to read:
1034 **Part 1. Individual and Small Employer Group**
1035 **31A-30-102. Purpose statement.**
1036 The purpose of this chapter is to:
1037 (1) prevent abusive rating practices;
1038 (2) require disclosure of rating practices to purchasers;

1039 (3) establish rules regarding:
1040 (a) a universal individual and small group application; and
1041 (b) renewability of coverage;
1042 (4) improve the overall fairness and efficiency of the individual and small group
1043 insurance market; [~~and~~]
1044 (5) provide increased access for individuals and small employers to health
1045 insurance[~~.~~]; and
1046 (6) provide an employer with the opportunity to establish a defined contribution
1047 arrangement for an employee to purchase a health benefit plan through the Internet portal
1048 created by Section 63M-1-2504.
1049 Section 11. Section **31A-30-103** is amended to read:
1050 **31A-30-103. Definitions.**
1051 As used in this chapter:
1052 (1) "Actuarial certification" means a written statement by a member of the American
1053 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
1054 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,
1055 including review of the appropriate records and of the actuarial assumptions and methods used
1056 by the covered carrier in establishing premium rates for applicable health benefit plans.
1057 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
1058 through one or more intermediaries, controls or is controlled by, or is under common control
1059 with, a specified entity or person.
1060 (3) "Base premium rate" means, for each class of business as to a rating period, the
1061 lowest premium rate charged or that could have been charged under a rating system for that
1062 class of business by the covered carrier to covered insureds with similar case characteristics
1063 for health benefit plans with the same or similar coverage.
1064 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan
1065 under [~~Subsection~~] Section 31A-22-613.5[~~(2)~~].
1066 (5) "Carrier" means any person or entity that provides health insurance in this state

1067 including:
1068 (a) an insurance company;
1069 (b) a prepaid hospital or medical care plan;
1070 (c) a health maintenance organization;
1071 (d) a multiple employer welfare arrangement; and
1072 (e) any other person or entity providing a health insurance plan under this title.
1073 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
1074 demographic or other objective characteristics of a covered insured that are considered by the
1075 carrier in determining premium rates for the covered insured.
1076 (b) "Case characteristics" do not include:
1077 (i) duration of coverage since the policy was issued;
1078 (ii) claim experience; and
1079 (iii) health status.
1080 (7) "Class of business" means all or a separate grouping of covered insureds
1081 established under Section 31A-30-105.
1082 (8) "Conversion policy" means a policy providing coverage under the conversion
1083 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.
1084 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
1085 this chapter.
1086 (10) "Covered individual" means any individual who is covered under a health benefit
1087 plan subject to this chapter.
1088 (11) "Covered insureds" means small employers and individuals who are issued a
1089 health benefit plan that is subject to this chapter.
1090 (12) "Dependent" means an individual to the extent that the individual is defined to be
1091 a dependent by:
1092 (a) the health benefit plan covering the covered individual; and
1093 (b) Chapter 22, Part 6, Accident and Health Insurance.
1094 (13) "Established geographic service area" means a geographical area approved by the

1095 commissioner within which the carrier is authorized to provide coverage.
1096 (14) "Index rate" means, for each class of business as to a rating period for covered
1097 insureds with similar case characteristics, the arithmetic average of the applicable base
1098 premium rate and the corresponding highest premium rate.
1099 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
1100 through a health benefit plan regardless of whether:
1101 (a) coverage is offered through:
1102 (i) an association;
1103 (ii) a trust;
1104 (iii) a discretionary group; or
1105 (iv) other similar groups; or
1106 (b) the policy or contract is situated out-of-state.
1107 (16) "Individual conversion policy" means a conversion policy issued to:
1108 (a) an individual; or
1109 (b) an individual with a family.
1110 (17) "Individual coverage count" means the number of natural persons covered under a
1111 carrier's health benefit products that are individual policies.
1112 (18) "Individual enrollment cap" means the percentage set by the commissioner in
1113 accordance with Section 31A-30-110.
1114 (19) "New business premium rate" means, for each class of business as to a rating
1115 period, the lowest premium rate charged or offered, or that could have been charged or offered,
1116 by the carrier to covered insureds with similar case characteristics for newly issued health
1117 benefit plans with the same or similar coverage.
1118 (20) "Plan year" means the year that is designated as the plan year in the plan
1119 document of a group health plan, except that if the plan document does not designate a plan
1120 year or if there is not a plan document, the plan year is:
1121 (a) the deductible or limit year used under the plan;
1122 (b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

1123 (c) if the plan does not impose a deductible or limit on a yearly basis and either the
1124 plan is not insured or the insurance policy is not renewed on an annual basis, the employer's
1125 taxable year; or
1126 (d) in any case not described in Subsections (20)(a) through (c), the calendar year.
1127 (21) "Preexisting condition" is as defined in Section 31A-1-301.
1128 (22) "Premium" means all monies paid by covered insureds and covered individuals as
1129 a condition of receiving coverage from a covered carrier, including any fees or other
1130 contributions associated with the health benefit plan.
1131 (23) (a) "Rating period" means the calendar period for which premium rates
1132 established by a covered carrier are assumed to be in effect, as determined by the carrier.
1133 (b) A covered carrier may not have:
1134 (i) more than one rating period in any calendar month; and
1135 (ii) no more than 12 rating periods in any calendar year.
1136 (24) "Resident" means an individual who has resided in this state for at least 12
1137 consecutive months immediately preceding the date of application.
1138 (25) "Short-term limited duration insurance" means a health benefit product that:
1139 (a) is not renewable; and
1140 (b) has an expiration date specified in the contract that is less than 364 days after the
1141 date the plan became effective.
1142 (26) "Small employer carrier" means a carrier that provides health benefit plans
1143 covering eligible employees of one or more small employers in this state, regardless of
1144 whether:
1145 (a) coverage is offered through:
1146 (i) an association;
1147 (ii) a trust;
1148 (iii) a discretionary group; or
1149 (iv) other similar grouping; or
1150 (b) the policy or contract is situated out-of-state.

1151 (27) "Uninsurable" means an individual who:
1152 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
1153 underwriting criteria established in Subsection 31A-29-111(5); or
1154 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
1155 (ii) has a condition of health that does not meet consistently applied underwriting
1156 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)
1157 and (j) for which coverage the applicant is applying.
1158 (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
1159 purposes of this formula:
1160 (a) "CI" means the carrier's individual coverage count as of December 31 of the
1161 preceding year; and
1162 (b) "UC" means the number of uninsurable individuals who were issued an individual
1163 policy on or after July 1, 1997.
1164 Section 12. Section **31A-30-104** is amended to read:
1165 **31A-30-104. Applicability and scope.**
1166 (1) This chapter applies to any:
1167 (a) health benefit plan that provides coverage to:
1168 (i) individuals;
1169 (ii) small employers; or
1170 (iii) both Subsections (1)(a)(i) and (ii); or
1171 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
1172 31A-30-107.5.
1173 (2) This chapter applies to a health benefit plan that provides coverage to small
1174 employers or individuals regardless of:
1175 (a) whether the contract is issued to:
1176 (i) an association;
1177 (ii) a trust;
1178 (iii) a discretionary group; or

1179 (iv) other similar grouping; or
1180 (b) the situs of delivery of the policy or contract.
1181 (3) This chapter does not apply to:
1182 (a) a large employer health benefit plan, except as specifically provided in Part 2,
1183 Defined Contribution Arrangements;
1184 (b) short-term limited duration health insurance; or
1185 (c) federally funded or partially funded programs.
1186 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:
1187 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
1188 return shall be treated as one carrier; and
1189 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
1190 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
1191 carriers were issued by one carrier.
1192 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
1193 maintenance organization having a certificate of authority under this title may be considered to
1194 be a separate carrier for the purposes of this chapter.
1195 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
1196 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
1197 arrangements with respect to health benefit plans delivered or issued for delivery to covered
1198 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
1199 obligation or risk for the health benefit plans being retained by the ceding carrier.
1200 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
1201 insurance obligation or risk with respect to one or more health benefit plans delivered or
1202 issued for delivery to covered insureds in this state.
1203 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
1204 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
1205 may make a written request to the commissioner for a waiver from the application of any of
1206 the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to

1207 the trust.
1208 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
1209 waiver if the commissioner finds that application with respect to the trust would:
1210 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
1211 and
1212 (ii) require significant modifications to one or more collective bargaining
1213 arrangements under which the trust is established or maintained.
1214 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
1215 person participates in a Taft Hartley trust as an associate member of any employee
1216 organization.
1217 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108,
1218 and 31A-30-111 apply to:
1219 (a) any insurer engaging in the business of insurance related to the risk of a small
1220 employer for medical, surgical, hospital, or ancillary health care expenses of the small
1221 employer's employees provided as an employee benefit; and
1222 (b) any contract of an insurer, other than a workers' compensation policy, related to the
1223 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
1224 small employer's employees provided as an employee benefit.
1225 (7) The commissioner may make rules requiring that the marketing practices be
1226 consistent with this chapter for:
1227 (a) a small employer carrier;
1228 (b) a small employer carrier's agent;
1229 (c) an insurance producer; and
1230 (d) an insurance consultant.
1231 Section 13. Section **31A-30-107** is amended to read:
1232 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
1233 **nonrenewal.**
1234 (1) Except as otherwise provided in this section, a small employer health benefit plan

1235 is renewable and continues in force:
1236 (a) with respect to all eligible employees and dependents; and
1237 (b) at the option of the plan sponsor.
1238 (2) A small employer health benefit plan may be discontinued or nonrenewed:
1239 (a) for a network plan, if:
1240 (i) there is no longer any enrollee under the group health plan who lives, resides, or
1241 works in:
1242 (A) the service area of the covered carrier; or
1243 (B) the area for which the covered carrier is authorized to do business; and
1244 (ii) in the case of the small employer market, the small employer carrier applies the
1245 same criteria the small employer carrier would apply in denying enrollment in the plan under
1246 Subsection 31A-30-108(7); or
1247 (b) for coverage made available in the small or large employer market only through an
1248 association, if:
1249 (i) the employer's membership in the association ceases; and
1250 (ii) the coverage is terminated uniformly without regard to any health status-related
1251 factor relating to any covered individual.
1252 (3) A small employer health benefit plan may be discontinued if:
1253 (a) a condition described in Subsection (2) exists;
1254 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
1255 premiums or contributions in accordance with the terms of the contract;
1256 (c) the plan sponsor:
1257 (i) performs an act or practice that constitutes fraud; or
1258 (ii) makes an intentional misrepresentation of material fact under the terms of the
1259 coverage;
1260 (d) the covered carrier:
1261 (i) elects to discontinue offering a particular small employer health benefit product
1262 delivered or issued for delivery in this state; and

1263 (ii) (A) provides notice of the discontinuation in writing:
1264 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee;
1265 and
1266 (II) at least 90 days before the date the coverage will be discontinued;
1267 (B) provides notice of the discontinuation in writing:
1268 (I) to the commissioner; and
1269 (II) at least three working days prior to the date the notice is sent to the affected plan
1270 sponsors, employees, and dependents of the plan sponsors or employees;
1271 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
1272 other small employer health benefit products currently being offered by the small employer
1273 carrier in the market; and
1274 (D) in exercising the option to discontinue that product and in offering the option of
1275 coverage in this section, acts uniformly without regard to:
1276 (I) the claims experience of a plan sponsor;
1277 (II) any health status-related factor relating to any covered participant or beneficiary;
1278 or
1279 (III) any health status-related factor relating to any new participant or beneficiary who
1280 may become eligible for the coverage; or
1281 (e) the covered carrier:
1282 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
1283 in:
1284 (A) the small employer market;
1285 (B) the large employer market; or
1286 (C) both the small employer and large employer markets; and
1287 (ii) (A) provides notice of the discontinuation in writing:
1288 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee;
1289 and
1290 (II) at least 180 days before the date the coverage will be discontinued;

1291 (B) provides notice of the discontinuation in writing:
1292 (I) to the commissioner in each state in which an affected insured individual is known
1293 to reside; and
1294 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1295 sponsors, employees, and the dependents of the plan sponsors or employees;
1296 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1297 market; and
1298 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
1299 (4) A small employer health benefit plan may be discontinued or nonrenewed:
1300 (a) if a condition described in Subsection (2) exists; or
1301 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1302 employer contribution requirements.
1303 (5) A small employer health benefit plan may be nonrenewed:
1304 (a) if a condition described in Subsection (2) exists; or
1305 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1306 minimum participation requirements.
1307 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
1308 discontinued if after issuance of coverage the eligible employee:
1309 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
1310 or
1311 (ii) makes an intentional misrepresentation of material fact in connection with the
1312 coverage.
1313 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
1314 (i) 12 months after the date of discontinuance; and
1315 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1316 to reenroll.
1317 (c) At the time the eligible employee's coverage is discontinued under Subsection
1318 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when

1319 coverage is discontinued.

1320 (d) An eligible employee may not be discontinued under this Subsection (6) because

1321 of a fraud or misrepresentation that relates to health status.

1322 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to

1323 the employer:

1324 (a) with respect to coverage provided to an employer member of the association; and

1325 (b) if the small employer health benefit plan is made available by a covered carrier in

1326 the employer market only through:

1327 (i) an association;

1328 (ii) a trust; or

1329 (iii) a discretionary group.

1330 (8) A covered carrier may modify a small employer health benefit plan only:

1331 (a) at the time of coverage renewal; and

1332 (b) if the modification is effective uniformly among all plans with that product.

1333 Section 14. Section **31A-30-109** is amended to read:

1334 **31A-30-109. Health benefit plan choices.**

1335 (1) An individual carrier who offers individual coverage pursuant to Section

1336 31A-30-108:

1337 (a) shall offer in the individual market under this chapter:

1338 (i) a choice of coverage that is at least equal to or greater than basic coverage[.]; and

1339 (ii) beginning January 1, 2010, the Utah NetCare Plan described in Subsection

1340 31A-22-724(2); and

1341 (b) may offer a choice of coverage that:

1342 (i) costs less than or equal to the plan described in Subsection (1)(a)(ii); and

1343 (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

1344 (2) Beginning January 1, 2010, a small employer group carrier who offers small

1345 employer group coverage pursuant to Section 31A-30-108:

1346 (a) shall offer in the small employer group market under this part:

1347 (i) a choice of coverage that is at least equal to or greater than basic coverage; and
1348 (ii) coverage under the Utah NetCare Plan described in Section 31A-22-724; and
1349 (b) may offer in the small employer group market under this part, a choice of coverage
1350 that:
1351 (i) costs less than or equal to the coverage in Subsection (2)(a); and
1352 (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).
1353 (3) Nothing in this section limits the number of health benefit plans an insurer may
1354 offer.
1355 Section 15. Section **31A-30-112** is amended to read:
1356 **31A-30-112. Employee participation levels.**
1357 (1) (a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement
1358 used by a covered carrier in determining whether to provide coverage to a small employer,
1359 including a requirement for minimum participation of eligible employees and minimum
1360 employer contributions, shall be applied uniformly among all small employers with the same
1361 number of eligible employees applying for coverage or receiving coverage from the covered
1362 carrier.
1363 (b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require
1364 that a small employer have a minimum of two eligible employees to meet participation
1365 requirements.
1366 (2) A covered carrier may not increase a requirement for minimum employee
1367 participation or a requirement for minimum employer contribution applicable to a small
1368 employer at any time after the small employer is accepted for coverage.
1369 Section 16. Section **31A-30-201** is enacted to read:
1370 **Part 2. Defined Contribution Arrangements**
1371 **31A-30-201. Title.**
1372 This part is known as "Defined Contribution Arrangements."
1373 Section 17. Section **31A-30-202** is enacted to read:
1374 **31A-30-202. Definitions.**

1375 For purposes of this part:
1376 (1) "Defined contribution arrangement" means a defined contribution arrangement
1377 employer group health benefit plan that:
1378 (a) complies with this part; and
1379 (b) is sold through the Internet portal in accordance with Title 63M, Chapter 1, Part
1380 25, Health System Reform Act.
1381 (2) "Health reimbursement arrangement" means an employer provided health
1382 reimbursement arrangement in which reimbursements for medical care expenses are excluded
1383 from an employee's gross income under the Internal Revenue Code.
1384 (3) "Producer" is as defined in Subsection 31A-23a-501(4)(a).
1385 (4) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies
1386 under Section 125, Internal Revenue Code, which permits an employee to contribute pre-tax
1387 dollars to a health benefit plan.
1388 (5) "Small employer" is defined in Section 31A-1-301.
1389 Section 18. Section **31A-30-203** is enacted to read:
1390 **31A-30-203. Eligibility for defined contribution arrangement market --**
1391 **Enrollment.**
1392 (1) (a) Beginning January 1, 2010, and during the open enrollment period described in
1393 Section 31A-30-208, an eligible small employer may choose to participate in a defined
1394 contribution arrangement.
1395 (b) Beginning January 1, 2012, and during the open enrollment period described in
1396 Section 31A-30-208, an eligible large employer may choose to participate in a defined
1397 contribution arrangement.
1398 (c) Defined contribution arrangement health benefit plans are employer group health
1399 plans individually selected by an employee of an employer.
1400 (2) (a) Participating insurers:
1401 (i) shall offer to accept all eligible employees of an employer described in Subsection
1402 (1), and their dependents, at the same level of benefits as anyone else who has the same health

1403 benefit plan in the defined contribution arrangement market; and
1404 (ii) may not impose a premium surcharge under Section 31A-30-106.7 in the defined
1405 contribution market.
1406 (b) A participating insurer may:
1407 (i) request an employer to submit a copy of the employer's quarterly wage list to
1408 determine whether the employees for whom coverage is provided or requested are bona fide
1409 employees of the employer; and
1410 (ii) deny or terminate coverage if the employer refuses to provide documentation
1411 requested under Subsection (2)(b)(i).
1412 Section 19. Section **31A-30-204** is enacted to read:
1413 **31A-30-204. Employer responsibilities -- Defined contribution arrangements.**
1414 (1) (a) (i) An employer described in Subsection 31A-30-203(1) that chooses to
1415 participate in a defined contribution arrangement may not offer a major medical health benefit
1416 plan that is not a part of the defined contribution arrangement to an employee.
1417 (ii) Subsection (1)(a)(i) does not prohibit the offer of supplemental or limited benefit
1418 policies such as dental or vision coverage, or other types of federally qualified savings
1419 accounts for health care expenses.
1420 (b) (i) To the extent permitted by the risk adjustment plan adopted under Section
1421 31A-42-202, the employer reserves the right to determine:
1422 (A) the criteria for employee eligibility, enrollment, and participation in the employer's
1423 health benefit plan; and
1424 (B) the amount of the employer's contribution to that plan.
1425 (ii) The determinations made under Subsection (1)(b) may only be changed during
1426 periods of open enrollment.
1427 (2) An employer that chooses to establish a defined contribution arrangement to
1428 provide a health benefit plan for its employees shall:
1429 (a) establish a mechanism for its employees to use pre-tax dollars to purchase a health
1430 benefit plan from the defined contribution arrangement market on the Internet portal created in

1431 Section 63M-1-2504, which may include:
1432 (i) a health reimbursement arrangement;
1433 (ii) a Section 125 Cafeteria plan; or
1434 (iii) another plan or arrangement similar to Subsection (2)(a)(i) or (ii) which is
1435 excluded or deducted from gross income under the Internal Revenue Code;
1436 (b) by November 10 of the open enrollment period:
1437 (i) inform each employee of the health benefit plan the employer has selected as the
1438 default health benefit plan for the employer group;
1439 (ii) offer each employee a choice of any of the health benefit plans available through
1440 the defined contribution arrangement market on the Internet portal; and
1441 (iii) notify the employee that the employee will be enrolled in the default health benefit
1442 plan selected by the employer and payroll deductions initiated for premium payments, unless
1443 the employee, prior to November 25 of the open enrollment period:
1444 (A) notifies the employer that the employee has selected a different health benefit plan
1445 available through the defined contribution arrangement in the Internet portal;
1446 (B) provides proof of coverage from another health benefit plan; or
1447 (C) specifically declines coverage in a health benefit plan.
1448 (3) An employer shall enroll an employee in the default health benefit plan selected by
1449 the employer if the employee does not make one of the choices described in Subsection
1450 (2)(b)(ii) prior to November 25 of the open enrollment period.
1451 (4) The employer's notice to the employee under Subsection (2)(b)(iii) shall inform the
1452 employee that the failure to act under Subsections (2)(b)(iii)(A) through (C) is considered an
1453 affirmative election under pre-tax payroll deductions for the employer to begin payroll
1454 deductions for health benefit plan premiums.
1455 Section 20. Section **31A-30-205** is enacted to read:
1456 **31A-30-205. Health benefit plans offered in the defined contribution market.**
1457 (1) An insurer who chooses to offer a health benefit plan in the defined contribution
1458 market must offer the following:

1459 (a) one health benefit plan that:
1460 (i) is a federally qualified high deductible health plan;
1461 (ii) has the lowest deductible permitted for a federally qualified high deductible health
1462 plan as adjusted by federal law; and
1463 (iii) does not exceed annual out-of-pocket maximum equal to three times the amount
1464 of the annual deductible; and
1465 (b) one health benefit plan with benefits that have an actuarial value at least 15%
1466 greater that the plan described in Subsection (1)(a).
1467 (2) The provisions of Subsection (1) do not limit the number of health benefit plans an
1468 insurer may offer in the defined contribution market. An insurer who offers the health benefit
1469 plans required by Subsection (1) may also offer any other health benefit plan in the defined
1470 contribution market if the health benefit plan provides benefits that are actuarially richer than
1471 the benefits required in Subsection (1)(a).
1472 Section 21. Section **31A-30-206** is enacted to read:
1473 **31A-30-206. Minimum participation and contribution levels -- Premium**
1474 **payments.**
1475 An insurer who offers a health benefit plan for which an employer has established a
1476 defined contribution arrangement under the provisions of this part:
1477 (1) shall not:
1478 (a) establish an employer minimum contribution level for the health benefit plan
1479 premium under Section 31A-30-112, or any other law; or
1480 (b) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to
1481 maintain a minimum employer contribution level;
1482 (2) shall accept premium payments for an enrollee from multiple sources through the
1483 Internet portal, including:
1484 (a) government assistance programs;
1485 (b) contributions from a Section 125 Cafeteria plan, a health reimbursement
1486 arrangement, or other qualified mechanism for pre-tax payments established by any employer

1487 of the enrollee;
1488 (c) contributions from a Section 125 Cafeteria plan, a health reimbursement
1489 arrangement, or other qualified mechanism for pre-tax payments established by an employer of
1490 a spouse or dependent of the enrollee; and
1491 (d) contributions from private sources of premium assistance; and
1492 (3) may require, as a condition of coverage, a minimum participation level for eligible
1493 employees of an employer, which for purposes of the defined contribution arrangement market
1494 may not exceed 75% participation.
1495 Section 22. Section **31A-30-207** is enacted to read:
1496 **31A-30-207. Rating and underwriting restrictions for defined contribution**
1497 **market.**
1498 (1) The rating and underwriting restrictions for the defined contribution market shall
1499 be established in accordance with the plan adopted under Chapter 42, Defined Contribution
1500 Risk Adjuster Act, and shall apply to employers who participate in the defined contribution
1501 arrangement market.
1502 (2) All insurers who participate in the defined contribution market must participate in
1503 the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster
1504 Act.
1505 Section 23. Section **31A-30-208** is enacted to read:
1506 **31A-30-208. Enrollment periods for the defined contribution market.**
1507 (1) From November 1 to November 30 of each year, an insurer offering a product in
1508 the defined contribution market shall administer an open enrollment period for plans effective
1509 January 1 following the November open enrollment period, during which an eligible employee
1510 may enroll in a health benefit plan offered through the defined contribution market and may
1511 not be declined coverage.
1512 (2) (a) Except as provided in Subsection (4), the period of open enrollment is the time
1513 in which an insurer may:
1514 (i) enter or exit the defined contribution market;

1515 (ii) offer new or modify existing products in the defined contribution market; or
1516 (iii) withdraw products from the defined contribution market.
1517 (b) Ninety days prior to an open enrollment period under Subsection (1), an insurer
1518 shall notify the Internet portal and the risk adjuster board created in Chapter 42, Defined
1519 Contribution Risk Adjuster Act, regarding any of the events described in Subsection (2)(a).
1520 (3) An eligible employee may enroll in a health benefit plan offered in the defined
1521 contribution market and may not be declined coverage, at a time other than the annual open
1522 enrollment period for any of the circumstances recognized as permissible under federal tax
1523 law, provided the individual does so within 63 days of the permissible circumstance.
1524 (4) When an insurer elects to participate in the defined contribution market, the
1525 insurer shall participate in the defined contribution market for no less than two years.
1526 Section 24. Section **31A-42-101** is enacted to read:
1527 **CHAPTER 42. DEFINED CONTRIBUTION RISK ADJUSTER ACT**
1528 **Part 1. General Provisions**
1529 **31A-42-101. Title.**
1530 This chapter is known as the "Defined Contribution Risk Adjuster Act."
1531 Section 25. Section **31A-42-102** is enacted to read:
1532 **31A-42-102. Definitions.**
1533 As used in this chapter:
1534 (1) "Board" means the board of directors of the Utah Defined Contribution Risk
1535 Adjuster created in Section 31A-42-201.
1536 (2) "Risk adjuster" means the defined contribution risk adjustment mechanism created
1537 in Section 31A-42-201.
1538 Section 26. Section **31A-42-103** is enacted to read:
1539 **31A-42-103. Applicability and scope.**
1540 This chapter applies to a carrier as defined in Section 31A-30-103 who offers a health
1541 benefit plan in a defined contribution arrangement under Chapter 30, Part 2, Defined
1542 Contribution Arrangements.

1543 Section 27. Section **31A-42-201** is enacted to read:

1544 **Part 2. Creation of Risk Adjuster Mechanism**

1545 **31A-42-201. Creation of defined contribution market risk adjuster mechanism --**
1546 **Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.**

1547 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity
1548 within the Insurance Department.

1549 (2) (a) The risk adjuster shall be under the direction of a board of directors composed
1550 of up to nine members described in Subsection (2)(b).

1551 (b) The following directors shall be appointed by the governor with the consent of the
1552 Senate:

1553 (i) at least three, but up to five directors with actuarial experience who represent
1554 insurance carriers:

1555 (A) that are participating or have committed to participate in the defined contribution
1556 arrangement market in the state; and

1557 (B) including at least one and up to two directors who represent a carrier that has a
1558 small percentage of lives in the defined contribution market;

1559 (ii) one director who represents either an individual employee or employer participant
1560 in the defined contribution market;

1561 (iii) one director appointed by the governor to represent the Office of Consumer
1562 Health Services within the Governor's Office of Economic Development;

1563 (iv) one director representing the Public Employee's Health Benefit Program with
1564 actuarial experience, chosen by the director of the Public Employee's Health Benefit Program
1565 who shall serve as an ex officio member; and

1566 (v) the commissioner or a representative from the department with actuarial
1567 experience appointed by the commissioner, who will only have voting privileges in the event
1568 of a tie vote.

1569 (3) (a) Except as required by Subsection (3)(b), as terms of current board members
1570 appointed by the governor expire, the governor shall appoint each new member or reappointed

1571 member to a four-year term.
1572 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
1573 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
1574 board members are staggered so that approximately half of the board is appointed every two
1575 years.
1576 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
1577 appointed for the unexpired term in the same manner as the original appointment was made.
1578 (5) (a) Members who are not government employees shall receive no compensation or
1579 benefits for the members' services.
1580 (b) A state government member who is a member because of the member's state
1581 government position may not receive per diem or expenses for the member's service.
1582 (6) The board shall elect annually a chair and vice chair from its membership.
1583 (7) Six board members are a quorum for the transaction of business.
1584 (8) The action of a majority of the members of the quorum is the action of the board.
1585 Section 28. Section **31A-42-202** is enacted to read:
1586 **31A-42-202. Contents of plan.**
1587 (1) The board shall submit a plan of operation for the risk adjuster to the
1588 commissioner. The plan shall:
1589 (a) establish the methodology for implementing Subsection (2) for the defined
1590 contribution arrangement market established under Chapter 30, Part 2, Defined Contribution
1591 Arrangements;
1592 (b) establish regular times and places for meetings of the board;
1593 (c) establish procedures for keeping records of all financial transactions and for
1594 sending annual fiscal reports to the commissioner;
1595 (d) contain additional provisions necessary and proper for the execution of the powers
1596 and duties of the risk adjuster; and
1597 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
1598 Code, to pay for administrative expenses incurred.

1599 (2) (a) The plan adopted by the board for the defined contribution arrangement market
1600 shall include:
1601 (i) parameters an employer may use to designate eligible employees for the defined
1602 contribution arrangement market; and
1603 (ii) underwriting mechanisms and employer eligibility guidelines:
1604 (A) consistent with the federal Health Insurance Portability and Accountability Act;
1605 and
1606 (B) necessary to protect insurance carriers from adverse selection in the defined
1607 contribution market.
1608 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
1609 qualified individual are determined, including:
1610 (i) the identification of an initial rate for a qualified individual based on:
1611 (A) standardized age bands submitted by participating insurers; and
1612 (B) wellness incentives for the individual as permitted by federal law; and
1613 (ii) the identification of a group risk factor to be applied to the initial age rate of a
1614 qualified individual based on the health conditions of all qualified individuals in the same
1615 employer group and, for small employers, in accordance with Sections 31A-30-105 and
1616 31A-30-106.
1617 (c) The plan adopted under Subsection (2)(a) shall outline how:
1618 (i) premium contributions for qualified individuals shall be submitted to the Internet
1619 portal in the amount determined under Subsection (2)(b); and
1620 (ii) the Internet portal shall distribute premiums to the insurers selected by qualified
1621 individuals within an employer group based on each individual's health risk factor determined
1622 in accordance with the plan.
1623 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
1624 risk between insurers that:
1625 (i) identifies health care conditions subject to risk adjustment;
1626 (ii) establishes an adjustment amount for each identified health care condition;

1627 (iii) determines the extent to which an insurer has more or less individuals with an
1628 identified health condition than would be expected; and
1629 (iv) computes all risk adjustments.
1630 (e) The board may amend the plan if necessary to:
1631 (i) maintain the solvency of the defined contribution market;
1632 (ii) mitigate significant issues of risk selection; or
1633 (iii) improve the administration of the risk adjuster mechanism.
1634 Section 29. Section **31A-42-203** is enacted to read:
1635 **31A-42-203. Powers and duties of board.**
1636 (1) The board shall have the power to:
1637 (a) enter into contracts to carry out the provisions and purposes of this chapter,
1638 including, with the approval of the commissioner, contracts with persons or other
1639 organizations for the performance of administrative functions;
1640 (b) sue or be sued, including taking legal action necessary to implement and enforce
1641 the plan for risk adjustment adopted pursuant to this chapter; and
1642 (c) establish appropriate rate adjustments, underwriting policies, and other actuarial
1643 functions appropriate to the operation of the defined contribution arrangement market in
1644 accordance with Section 31A-42-202.
1645 (2) (a) The board shall prepare and submit an annual report to the department for
1646 inclusion in the department's annual market report, which shall include:
1647 (i) the expenses of administration of the risk adjuster for the defined contribution
1648 arrangement market;
1649 (ii) a description of the types of policies sold in the defined contribution arrangement
1650 market;
1651 (iii) the number of insured lives in the defined contribution arrangement market; and
1652 (iv) the number of insured lives in health benefit plans that do not include state
1653 mandates.
1654 (b) The budget for operation of the risk adjuster is subject to the approval of the board.

1655 (c) The administrative budget of the board and the commissioner under this chapter
1656 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
1657 subject to review and approval by the Legislature.
1658 (3) The board shall report to the Health Reform Task Force and to the Legislative
1659 Management Committee prior to October 1, 2009 and again prior to October 1, 2010
1660 regarding:
1661 (a) the board's progress in developing the plan required by this chapter; and
1662 (b) the board's progress in:
1663 (i) expanding choice of plans in the defined contribution market; and
1664 (ii) expanding access to the defined contribution market in the Internet portal for large
1665 employer groups.
1666 Section 30. Section **31A-42-204** is enacted to read:
1667 **31A-42-204. Powers of commissioner.**
1668 (1) The commissioner shall, after notice and hearing, approve the plan of operation if
1669 the commissioner determines that the plan:
1670 (a) is consistent with this chapter; and
1671 (b) is a fair and reasonable administration of the risk adjuster.
1672 (2) The plan shall be effective upon the adoption of administrative rules by the
1673 commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
1674 (3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any
1675 time thereafter fails to submit proposed amendments to the plan of operation within a
1676 reasonable time after requested by the commissioner, the commissioner shall, after notice and
1677 hearing, adopt such rules as necessary to effectuate the provisions of this chapter.
1678 (4) Rules promulgated by the commissioner shall continue in force until modified by
1679 the commissioner or until superseded by a subsequent plan of operation submitted by the
1680 board and approved by the commissioner.
1681 (5) The commissioner may designate an executive secretary from the department to
1682 provide administrative assistance to the board in carrying out its responsibilities.

1683 Section 31. Section **63M-1-2504** is amended to read:

1684 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**

1685 (1) There is created within the Governor's Office of Economic Development the Office
1686 of Consumer Health Services.

1687 (2) The office shall:

1688 (a) in cooperation with the Insurance Department, the Department of Health, and the
1689 Department of Workforce Services, and in accordance with the electronic standards developed
1690 under [~~Section~~] Sections 31A-22-635 and 63M-1-2506, create an Internet portal that:

1691 (i) is capable of providing access to private and government health insurance websites
1692 and their electronic application forms and submission procedures;

1693 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
1694 on the Internet portal by an insurer for the:

1695 (A) small employer group market;

1696 (B) the individual market; and

1697 (C) the defined contribution arrangement market; and

1698 (iii) includes information and a link to enrollment in premium assistance programs
1699 and other government assistance programs;

1700 (b) facilitate a private sector method for the collection of health insurance premium
1701 payments made for a single policy by multiple payers, including the policyholder, one or more
1702 employers of one or more individuals covered by the policy, government programs, and others
1703 by educating employers and insurers about collection services available through private
1704 vendors, including financial institutions; [~~and~~]

1705 (c) assist employers with a free or low cost method for establishing mechanisms for
1706 the purchase of health insurance by employees using pre-tax dollars[~~.~~];

1707 (d) periodically convene health care providers, payers, and consumers to monitor the
1708 progress being made regarding demonstration projects for health care delivery and payment
1709 reform; and

1710 (e) report to the Business and Labor Interim Committee and the Health Reform Task

1711 Force prior to November 1, 2009 and November 1, 2010 regarding:
1712 (i) the operations of the Internet portal required by this chapter; and
1713 (ii) the progress of the demonstration projects for health care payment and delivery
1714 reform.
1715 (3) The office:
1716 (a) may not:
1717 [(a)] (i) regulate health insurers, health insurance plans, or health insurance producers;
1718 [(b)] (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or
1719 [(c)] (iii) act as an appeals entity for resolving disputes between a health insurer and
1720 an insured[.]; and
1721 (b) may establish and collect a fee in accordance with Section 63J-1-303 for the
1722 transaction cost of:
1723 (i) processing an application for a health benefit plan from the Internet portal to an
1724 insurer; and
1725 (ii) accepting, processing, and submitting multiple premium payment sources.
1726 Section 32. Section **63M-1-2506** is enacted to read:
1727 **63M-1-2506. Health benefit plan information on Internet portal -- Insurer**
1728 **transparency.**
1729 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,
1730 Chapter 3, Utah Administrative Rulemaking Act, that:
1731 (i) establish uniform electronic standards for:
1732 (A) a health insurer to use when:
1733 (I) transmitting information to the Internet portal; or
1734 (II) receiving information from the Internet portal; and
1735 (B) facilitating the transmission and receipt of premium payments from multiple
1736 sources in the defined contribution arrangement market;
1737 (ii) designate the level of detail that would be helpful for a concise consumer
1738 comparison of the items described in Subsections (4)(a) through (d) on the Internet portal; and

1739 (iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined
1740 Contribution Risk Adjuster Act, and carriers participating in the defined contribution market
1741 on the Internet portal with the determination of when an employer is eligible to participate in
1742 the Internet portal defined contribution market under Title 31A, Chapter 30, Part 2, Defined
1743 Contribution Arrangements.
1744 (b) The office shall post or facilitate the posting of:
1745 (i) the information required by this section on the Internet portal created by this part;
1746 and
1747 (ii) links to websites that provide cost and quality information from the Department of
1748 Health Data Committee or neutral entities with a broad base of support from the provider and
1749 payer communities.
1750 (2) A health insurer shall use the uniform electronic standards when transmitting
1751 information to the Internet portal or receiving information from the Internet portal.
1752 (3) (a) An insurer who participates in the defined contribution arrangement market
1753 under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans
1754 offered in that market on the Internet portal and shall comply with the provisions of this
1755 section.
1756 (b) An insurer who offers products under Title 31A, Chapter 30, Part 1, Individual and
1757 Small Employer Group:
1758 (i) shall post the basic benefit plan required by Section 31A-22-613.5 for individual
1759 and small employer group plans on the Internet portal if the insurer's plans are offered to the
1760 general public;
1761 (ii) may publish any other health benefit plans that it offers on the Internet portal; and
1762 (iii) shall comply with the provisions of this section for every health benefit plan it
1763 posts on the Internet portal.
1764 (4) A health insurer shall provide the Internet portal with the following information for
1765 each health benefit plan submitted to the Internet portal:
1766 (a) plan design, benefits, and options offered by the health benefit plan including state

1767 mandates the plan does not cover;
1768 (b) provider networks;
1769 (c) wellness programs and incentives;
1770 (d) descriptions of prescription drug benefits, exclusions, or limitations; and
1771 (e) at the same time as information is submitted under Subsection 31A-30-208(2), the
1772 following operational measures for each health insurer that submits information to the Internet
1773 portal:
1774 (i) the percentage of claims paid by the insurer within 30 days of the date a claim is
1775 submitted to the insurer for the prior year; and
1776 (ii) the number of adverse benefit determinations by the insurer which were
1777 subsequently overturned on independent review under Section 31A-22-629 as a percentage of
1778 total claims paid by the insurer for the prior year.
1779 (5) The Insurance Department shall post on the Internet portal the Insurance
1780 Department's solvency rating for each insurer who posts a health benefit plan on the Internet
1781 portal. The solvency rating for each carrier shall be based on methodology established by the
1782 Insurance Department by administrative rule and shall be updated each calendar year.
1783 (6) The commissioner may request information from an insurer under Section
1784 31A-22-613.5 to verify the data submitted to the Internet portal under this section.
1785 (7) A health insurer shall accept and process an application for a health benefit plan
1786 from the Internet portal in accordance with Section 31A-22-635.
1787 Section 33. **Health Reform Task Force -- Creation -- Membership -- Interim rules**
1788 **followed -- Compensation -- Staff.**
1789 (1) There is created the Health Reform Task Force consisting of the following 11
1790 members:
1791 (a) four members of the Senate appointed by the president of the Senate, no more than
1792 three of whom may be from the same political party; and
1793 (b) seven members of the House of Representatives appointed by the speaker of the
1794 House of Representatives, no more than five of whom may be from the same political party.

1795 (2) (a) The president of the Senate shall designate a member of the Senate appointed
1796 under Subsection (1)(a) as a co-chair of the committee.
1797 (b) The speaker of the House of Representatives shall designate a member of the
1798 House of Representatives appointed under Subsection (1)(b) as a co-chair of the committee.
1799 (3) In conducting its business, the committee shall comply with the rules of legislative
1800 interim committees.
1801 (4) Salaries and expenses of the members of the committee shall be paid in accordance
1802 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
1803 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
1804 Sessions.
1805 (5) The Office of Legislative Research and General Counsel shall provide staff support
1806 to the committee.
1807 Section 34. **Duties -- Interim report.**
1808 (1) The committee shall review and make recommendations on the following issues:
1809 (a) the state's progress in implementing the strategic plan for health system reform as
1810 described in Section 63M-1-2505;
1811 (b) the implementation of statewide demonstration projects to provide systemwide
1812 aligned incentives for the appropriate delivery of and payment for health care;
1813 (c) the development of the defined contribution arrangement market and the plan
1814 developed by the risk adjuster board for implementation by January 1, 2012, including:
1815 (i) increased selection of health benefit plans in the defined contribution market;
1816 (ii) participation by large employer groups in the defined contribution market; and
1817 (iii) risk allocation in the defined contribution market;
1818 (d) the operations and progress of the Internet portal;
1819 (e) mechanisms to increase transparency in the market, including:
1820 (i) developing measurements and methodology for insurers to provide medical loss
1821 ratios as a percentage of premiums; and
1822 (ii) administrative overhead as a percentage of total revenue;

1823 (f) the implementation and effectiveness of insurer wellness programs and incentives,
1824 including outcome measures for the programs; and
1825 (g) clarification from the U.S. Department of Labor regarding whether the federal
1826 Health Insurance Portability and Accountability Act, federal ERISA laws, and the Internal
1827 Revenue Code will permit an employer to offer pre-tax income to an individual for the
1828 purchase of a health benefit policy in the defined contribution market and allow the individual
1829 to purchase a health benefit policy that:
1830 (i) is owned by the individual, separate from the employer group plan; and
1831 (ii) is not subject to the employment relationship with the employer and is therefore
1832 fully portable;
1833 (h) development of strategies for promoting health and wellness and highlighting the
1834 health risks associated with such things as obesity and sedentary lifestyles;
1835 (i) providing greater transparency for consumers by:
1836 (A) increasing the ability of individuals to obtain pre-service estimates from health
1837 care providers;
1838 (B) determining, with providers, payers, and consumers how to make the insurance
1839 explanation of benefits more understandable;
1840 (C) determining if the terminology used by insurers regarding copayments,
1841 deductibles, and cost sharing can be standardized or made more understandable to consumers
1842 and providers; and
1843 (D) developing with providers and insurers a more efficient process for
1844 pre-authorization from an insurer for a medical procedure;
1845 (j) the nature and significance of cost shifting between public programs and private
1846 insurance, and exploring strategies for reducing the level of the cost shift;
1847 (k) the role that the Public Employees Health Program and other associations that
1848 provide insurance may play in the defined contribution market portal;
1849 (l) the development of strategies to keep community leaders, business leaders, and the
1850 public involved in the process of health care reform;

1851 (m) the development of a process to help the public understand the circumstances
1852 underlying significant cost increase within the healthcare market or regional treatment
1853 variances; and
1854 (n) the consideration of insurance reimbursement disincentives for a healthcare
1855 provider to choose the most effective and efficient treatment method for a patient.
1856 (2) A final report, including any proposed legislation shall be presented to the
1857 Business and Labor Interim Committee before November 30, 2009.
1858 Section 35. **Effective date.**
1859 If approved by two-thirds of all the members elected to each house, this bill takes effect
1860 upon approval by the governor, or the day following the constitutional time limit of Utah
1861 Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto,
1862 the date of veto override.
1863 Section 36. **Repeal date.**
1864 The Health System Reform Task Force created in Sections 33 and 34 of this bill is
1865 repealed December 30, 2009.