LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: C.J. Dupont ₵
₵ 03-12-09 10:50 AM ₵

HEALTH INSURANCE AND PROGRAM AMENDMENTS

2009 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends the Insurance Code and the Children's Health Insurance Program.

Highlighted Provisions:

This bill:

- clarifies that the Children's Health Insurance Program should have access to at least two different provider networks;
- extends the COBRA premium assistance provided under the Federal Funds - American Recovery and Reinvestment Act (HR1, 111th United States Congress) to state mini-COBRA benefits;
- provides a July 1, 2009 effective date for:
  - the extension of mini-COBRA benefits from 6 months to 12 months; and
  - the change in the mini-COBRA eligibility waiting period; and
- makes technical amendments to the health benefit plan broker disclosure requirement.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill coordinates with H.B. 188, Health System Reform-Insurance Market, by providing that parts of this bill supersede parts of H.B. 188.

H.B. 178

Utah Code Sections Affected:

AMENDS:

26-40-110, as last amended by Laws of Utah 2008, Chapters 208 and 382

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

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

ENACTS:

31A-22-722.5, Utah Code Annotated 1953

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

Section 1. Section **26-40-110** is amended to read:

26-40-110. Managed care -- Contracting for services.

(1) Program benefits provided to enrollees under the program, as described in Section 26-40-106, shall be delivered in a managed care system if the department determines that adequate services are available where the enrollee lives or resides.

(2) (a) The department shall use the following criteria to evaluate bids from health plans:

(i) ability to manage medical expenses, including mental health costs;

(ii) proven ability to handle accident and health insurance;

(iii) efficiency of claim paying procedures;

(iv) proven ability for managed care and quality assurance;

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) an estimate of total charges for administering the pool;

(viii) ability to administer the pool in a cost-efficient manner;

(ix) the ability to provide adequate providers and services in the state; and

(x) other criteria established by the department.

(b) The dental benefits required by Section 26-40-106 may be bid out separately from other program benefits.

(c) Except for dental benefits, the department shall request bids for the program's benefits in 2008. The department shall request bids for the program's dental benefits in 2009. The department shall request bids for the program's benefits at least once every five years

thereafter.

(d) The department's contract with health plans for the program's benefits shall include risk sharing provisions in which the health plan must accept at least 75% of the risk for any difference between the department's premium payments per client and actual medical expenditures.

(3) The executive director shall report to and seek recommendations from the Health Advisory Council created in Section 26-1-7.5:

(a) if the division receives less than two bids or proposals under Subsection (1) that are acceptable to the division or responsive to the bid; and

(b) before awarding a contract to a managed care system.

(4) (a) The department shall award contracts to [~~at least two~~] responsive bidders:

(i) if the department determines that [~~two or more bids are~~] a bid is acceptable and [~~meet~~] meets the criteria of Subsections (2)(a) and (d)[~~.~~]; and

(ii) (A) the responsive bidder is able to offer the program access to two different provider networks; or

(B) the selection of two different responsive bidders will provide the program with access to two different provider networks.

(b) The department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1) if:

(i) the department is not able to contract with [~~at least two private carriers~~] private carriers that under Subsection (4)(a) are able to provide the program access to two different provider networks;

(ii) the executive director seeks the recommendation of the Health Advisory Council under Subsection (3); and

(iii) the executive director determines that either:

(A) [~~at least two~~] responsive bids that could provide the program with access to two different provider networks were not received by the department; or

(B) [~~less than two~~] the bids were not acceptable to the department.

(c) In accordance with Section 49-20-201, a contract awarded under Subsection (4)(b) is not subject to the risk sharing required by Subsection (2)(d).

(5) Title 63G, Chapter 6, Utah Procurement Code, shall apply to this section.

Section 2. Section **31A-22-722** is amended to read:

31A-22-722. Utah mini-COBRA benefits for employer group coverage.

(1) An insured has the right to extend the employee's coverage under the current employer's group policy for a period of six months until May 14, 2009, and beginning May 15, 2009, for a period of 12 months, except as provided in Subsection (2). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) any disability;

(i) leave of absence; or

(j) reduction of hours.

(2) (a) Notwithstanding the provisions of Subsection (1), an employee does not have the right to extend coverage under the current employer's group policy if the employee:

(i) failed to pay any required individual contribution;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performed an act or practice that constitutes fraud in connection with the coverage;

(iv) made an intentional misrepresentation of material fact under the terms of the coverage;

(v) was terminated for gross misconduct;

(vi) has not been continuously covered under the current employer's group policy for a period of six months immediately prior to the termination of the policy until May 14, 2009, and beginning May 15, 2009, for a period of three months immediately prior to the termination of the policy, due to the events set forth in Subsection (1); [~~or~~]

(vii) is eligible for any extension of coverage required by federal law[~~.~~]; or

(viii) elected alternative coverage under Section 31A-22-724.

(b) The right to extend coverage under Subsection (1) applies to any spouse or dependent coverages, including a surviving spouse or dependents whose coverage under the policy terminates by reason of the death of the employee or member.

(3) (a) The employer shall provide written notification of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made to:

(i) the terminated insured;

(ii) the ex-spouse; or

(iii) if Subsection (2)(b) applies:

(A) to a surviving spouse; and

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

(b) The notification shall be sent first class mail within 30 days after the termination date of the group coverage to:

(i) the terminated insured's home address as shown on the records of the employer;

(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;

(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and

(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in [~~this~~] Subsection [~~(3)~~] (5) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and

(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.

(5) The premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(6) (a) Except as provided in this Subsection (6)[~~,~~]:

(i) the coverage extends without interruption for:

(A) six months [~~and~~] if the election is made prior to May 14, 2009; and

(B) 12 months if the election is made beginning May 15, 2009; and

(b) may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

[~~(a)~~] (i) elects to extend group coverage within 60 days of losing group coverage; and

[~~(b)~~] (ii) tenders the amount required to the employer or insurer.

(7) The insured's coverage may be terminated prior to [~~six months~~] the period of time designated in Subsection (6) if the terminated insured:

(a) establishes residence outside of this state;

(b) moves out of the insurer's service area;

(c) fails to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(d) performs an act or practice that constitutes fraud in connection with the coverage;

(e) makes an intentional misrepresentation of material fact under the terms of the coverage;

(f) becomes eligible for similar coverage under another group policy; or

(g) employer's coverage is terminated, except as provided in Subsection (8).

(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have the right to obtain extension of coverage under the replacement group policy:

(a) for the balance of the period the terminated insured would have extended coverage under the replaced group policy; and

(b) if the terminated insured is otherwise eligible for extension of coverage.

(9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of the insured, the surviving spouse, or guardian of any dependents, written notification of the right to an individual conversion policy under Section 31A-22-723.

(b) The notification required by Subsection (9)(a):

(i) shall be sent first class mail to:

(A) the insured's last-known address as shown on the records of the employer;

(B) the address of the surviving spouse, if different from the insured's address, and if shown on the records of the employer;

(C) the guardian of any dependents last known address as shown on the records of the employer, if different from the address of the surviving spouse; and

(D) the address of the ex-spouse as shown on the records of the employer, if applicable; and

(ii) shall contain the name, address, and telephone number of the insurer that will provide the conversion coverage.

Section 3. Section **31A-22-722.5** is enacted to read:

31A-22-722.5. Mini-COBRA election -- American Recovery and Reinvestment Act.

(1) An insurer shall offer a second election period for mini-COBRA benefits under Section 31A-22-722 in accordance with the Federal Funds - American Recovery and Reinvestment Act (HR1, 111th United States Congress) to an individual who:

(a) was involuntarily terminated from employment between September 1, 2008 and February 17, 2009, as defined in the Federal Funds - American Recovery and Reinvestment Act (HR1, 111th United States Congress); and

(b) is eligible for COBRA premium assistance under the Federal Funds - American Recovery and Reinvestment Act (HR1, 111th United States Congress).

(2) An insurer:

(a) may provide notice to an individual of the individual's right to a second chance to elect mini-COBRA under the provisions of the Federal Funds - American Recovery and Reinvestment Act (HR1, 111th United States Congress); and

(b) shall provide an individual with the forms and information needed to enroll in the mini-COBRA coverage if the individual or the employer of the individual contacts the insurer and informs the insurer that the individual wants to take advantage of the second election period.

(3) The provision regarding the application of pre-existing condition waivers to the extended second election period for federal COBRA under the Federal Funds - American Recovery and Reinvestment Act (HR1, 111th United States Congress) shall apply to the extended second election for state mini-COBRA under this section.

(4) An insurer that violates this section is subject to penalties in accordance with Section 31A-2-308.

Section 4. Section **31A-23a-501** is amended to read:

31A-23a-501. Licensee compensation.

(1) As used in this section:

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

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

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

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

(A) whether or not payable pursuant to a written agreement; and

(B) received from:

(I) an insurer; or

(II) a third party to the transaction for the sale or placement of insurance.

(ii) "Compensation from an insurer or third party administrator" does not mean compensation from a customer that is:

(A) a fee or pass-through costs as provided in Subsection (1)(e); or

(B) a fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner by administrative rule.

(c) (i) "Customer" means:

(A) the person signing the application or submission for insurance; or

(B) the authorized representative of the insured actually negotiating the placement of insurance with the producer.

(ii) "Customer" does not mean a person who is a participant or beneficiary of:

(A) an employee benefit plan; or

(B) a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the producer or affiliate.

[~~(b)~~] (d) (i) "Noncommission compensation" includes all funds paid to or credited for the benefit of a licensee other than commission compensation.

(ii) "Noncommission compensation" does not include charges for pass-through costs incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

[~~(c)~~] (e) "Pass-through costs" include:

(i) costs for copying documents to be submitted to the insurer; and

(ii) bank costs for processing cash or credit card payments.

(2) A licensee may receive from an insured or from a person purchasing an insurance policy, noncommission compensation if the noncommission compensation is stated on a separate, written disclosure.

(a) The disclosure required by this Subsection (2) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(b) Noncommission compensation shall be:

(i) limited to actual or reasonable expenses incurred for services; and

(ii) uniformly applied to all insureds or prospective insureds in a class or classes of business or for a specific service or services.

(c) A copy of the signed disclosure required by this Subsection (2) must be maintained by any licensee who collects or receives the noncommission compensation or any portion [~~thereof~~] of the noncommission compensation.

(d) All accounting records relating to noncommission compensation shall be maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

(3) (a) A licensee may receive noncommission compensation when acting as a producer for the insured in connection with the actual sale or placement of insurance if:

(i) the producer and the insured have agreed on the producer's noncommission compensation; and

(ii) the producer has disclosed to the insured the existence and source of any other compensation that accrues to the producer as a result of the transaction.

(b) The disclosure required by this Subsection (3) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation and the existence and source of any other compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(c) The following additional noncommission compensation is authorized:

(i) compensation received by a producer of a compensated corporate surety who under procedures approved by a rule or order of the commissioner is paid by surety bond principal debtors for extra services;

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

(iii) compensation received by a consultant as a consulting fee, provided the consultant complies with the requirements of Section 31A-23a-401; or

(iv) other compensation arrangements approved by the commissioner after a finding that they do not violate Section 31A-23a-401 and are not harmful to the public.

(4) (a) For purposes of this Subsection (4), "producer" includes:

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) Beginning January 1, 2010, in addition to any other disclosures required by this section, a producer may not accept or receive any compensation from an insurer or third party administrator for the placement of a health benefit plan, other than a hospital confinement indemnity policy, unless prior to the customer's purchase of the health benefit plan the producer:

(i) except as provided in Subsection (4)(c), discloses in writing to the customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer

at the time of the disclosure; and

(ii) except as provided in Subsection (4)(c):

(A) obtains the customer's signed acknowledgment that the disclosure under Subsection (4)(b)(i) was made to the customer; or

(B) certifies to the insurer that the disclosure required by Subsection (4)(b)(i) was made to the customer.

(c) If the compensation to the producer from an insurer or third party administrator is for the renewal of a health benefit plan, once the producer has made an initial disclosure that complies with Subsection (4)(b), the producer does not have to disclose compensation received for the subsequent yearly renewals in accordance with Subsection (4)(b) until the renewal period immediately following 36 months after the initial disclosure.

(d) (i) A copy of the signed acknowledgment required by Subsection (4)(b) must be maintained by the licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit.

(ii) The standard application developed in accordance with Section 31A-22-635 shall include a place for a producer to provide the disclosure required by this Subsection (4), and if completed, shall satisfy the requirement of Subsection (4)(d)(i).

(e) Subsection (4)(b)(ii) does not apply to:

(i) a person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent; or

(ii) the placement of insurance in a secondary or residual market.

[~~(4)~~] (5) This section does not alter the right of any licensee to recover from an insured the amount of any premium due for insurance effected by or through that licensee or to charge a reasonable rate of interest upon past-due accounts.

[~~(5)~~] (6) This section does not apply to bail bond producers or bail enforcement agents as defined in Section 31A-35-102.

Section 5. **Coordinating H.B. 178 with H.B. 188 -- Substantively superseding amendments.**

If this H.B. 178 and H.B. 188, Health System Reform - Insurance Market, both pass, it is the intent of the Legislature that Sections 31A-22-722 and 31A-23a-501 in this H.B. 178 supersede the provisions of Sections 31A-22-722 and 31A-23a-501 in H.B. 188, when the

Office of Legislative Research and General Counsel prepares the Utah Code database for publication.

Legislative Review Note
as of 3-12-09 9:55 AM

Office of Legislative Research and General Counsel