

**Senator Gregory S. Bell** proposes the following substitute bill:

**HEALTH SYSTEM REFORM - INSURANCE**

**MARKET**

2009 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: David Clark**

Senate Sponsor: Gregory S. Bell

Cosponsors:

Brad L. Dee

David Litvack

Roger E. Barrus

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Ron Bigelow

Kevin S. Garn

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Bradley M. Daw

Bradley G. Last

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**LONG TITLE**

**General Description:**

This bill amends the Insurance Code and the Governor's Office of Economic Development Code to expand access to the health insurance market, increase market flexibility, and provide greater transparency in the health insurance market.

**Highlighted Provisions:**

This bill:

- ▶ prohibits balanced billing by certain health care providers in certain circumstances;
- ▶ revises the basic benefit plan used for consumer comparison of health benefit

products;

- ▶ requires the Insurance Department to include in its annual market report a summary of the types of plans sold through the Internet portal, including market penetration of mandate lite products;

- ▶ allows insurers to offer lower cost health insurance products that do not include 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 care  
52 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 payment  
55 reform demonstration projects;

56       ▶ establishes limited rulemaking authority for the Office of Consumer Health Services  
57 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

**Uncodified Material Affected:**

ENACTS UNCODIFIED MATERIAL

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

Section 1. Section **31A-8-501** is amended to read:

**31A-8-501. Access to health care providers.**

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for 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 health  
141 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 or  
169 the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it  
170 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 who  
175 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 accordance  
181 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 notice  
202 in any health maintenance organization's provider list that is supplied to enrollees, including  
203 any website maintained by the health maintenance organization;

204           (ii) failing to provide notice of an enrollee'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 as

240 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 this  
278 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 the~~  
291 ~~Legislature's Health and Human Services Interim Committee and Business and Labor Interim~~  
292 ~~Committee, either collectively or independently regarding insurer efforts to inform enrollees of~~  
293 ~~any limitation of coverage or exclusion for a secondary medical condition when an enrollee, or~~  
294 ~~someone on the enrollee's behalf, contacts the insurer for pre-authorization of a procedure or~~  
295 ~~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 amount  
314 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 for  
353 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 as  
371 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 the  
377 specified payment as payment in full, relinquishing the right to collect additional amounts from  
378 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 except  
384 the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)  
385 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the  
386 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 ownership  
390 or control to use or otherwise lease one or more of the organization's networks of participating  
391 providers, the organization shall ensure, at a minimum, that the entity pays participating  
392 providers in accordance with the same fee schedule and general payment policies as the  
393 organization would for that network.

394 (b) The insurance contract may reward the insured for selection of preferred health care  
395 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 organization
- 418 has not been reduced to writing, or the contract fails to contain the language required by
- 419 Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
- 420 (A) sums owed by the insolvent managed care organization; or
- 421 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
- 422 (iv) the following may not bill or maintain any action at law against an enrollee to
- 423 collect sums owed by the insolvent managed care organization or the amount of the regular fee
- 424 reduction authorized under Subsection (1)(c)(i)(B):
- 425 (A) a provider;
- 426 (B) an agent;
- 427 (C) a trustee; or
- 428 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
- 429 (v) notwithstanding Subsection (1)(c)(i):

430 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's  
431 regular fee set forth in the contract; and

432 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments  
433 for services received from the provider that the enrollee was required to pay before the filing  
434 of:

435 (I) a petition for rehabilitation; or

436 (II) a petition for liquidation.

437 (2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health  
438 care provider contracts shall pay for the services of health care providers not under the contract,  
439 unless the illnesses or injuries treated by the health care provider are not within the scope of the  
440 insurance contract. As used in this section, "class of health care providers" means all health  
441 care providers licensed or licensed and certified by the state within the same professional,  
442 trade, occupational, or facility licensure or licensure and certification category established  
443 pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions.

444 (b) [~~When~~] (i) Until July 1, 2012, when the insured receives services from a health  
445 care provider not under contract, the insurer shall reimburse the insured for at least 75% of the  
446 average amount paid by the insurer for comparable services of preferred health care providers  
447 who are members of the same class of health care providers.

448 (ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that  
449 complies with the provisions of Subsection 31A-22-618.5(3).

450 (iii) The commissioner may adopt a rule dealing with the determination of what  
451 constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for  
452 comparable services of preferred health care providers who are members of the same class of  
453 health care providers.

454 (c) When reimbursing for services of health care providers not under contract, the  
455 insurer may make direct payment to the insured.

456 (d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider  
457 contracts may impose a deductible on coverage of health care providers not under contract.

458 (e) When selecting health care providers with whom to contract under Subsection (1),  
459 an insurer may not unfairly discriminate between classes of health care providers, but may  
460 discriminate within a class of health care providers, subject to Subsection (7).

461 (f) For purposes of this section, unfair discrimination between classes of health care  
462 providers shall include:

463 (i) refusal to contract with class members in reasonable proportion to the number of  
464 insureds covered by the insurer and the expected demand for services from class members; and

465 (ii) refusal to cover procedures for one class of providers that are:

466 (A) commonly utilized by members of the class of health care providers for the  
467 treatment of illnesses, injuries, or conditions;

468 (B) otherwise covered by the insurer; and

469 (C) within the scope of practice of the class of health care providers.

470 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose  
471 to the insured that it has entered into preferred health care provider contracts. The insurer shall  
472 provide sufficient detail on the preferred health care provider contracts to permit the insured to  
473 agree to the terms of the insurance contract. The insurer shall provide at least the following  
474 information:

475 (a) a list of the health care providers under contract and if requested their business  
476 locations and specialties;

477 (b) a description of the insured benefits, including any deductibles, coinsurance, or  
478 other copayments;

479 (c) a description of the quality assurance program required under Subsection (4); and

480 (d) a description of the adverse benefit determination procedures required under  
481 Subsection (5).

482 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality  
483 assurance program for assuring that the care provided by the health care providers under  
484 contract meets prevailing standards in the state.

485 (b) The commissioner in consultation with the executive director of the Department of  
486 Health may designate qualified persons to perform an audit of the quality assurance program.  
487 The auditors shall have full access to all records of the organization and its health care  
488 providers, including medical records of individual patients.

489 (c) The information contained in the medical records of individual patients shall  
490 remain confidential. All information, interviews, reports, statements, memoranda, or other data  
491 furnished for purposes of the audit and any findings or conclusions of the auditors are



492 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal  
493 proceeding except hearings before the commissioner concerning alleged violations of this  
494 section.

495 (5) An insurer using preferred health care provider contracts shall provide a reasonable  
496 procedure for resolving complaints and adverse benefit determinations initiated by the insureds  
497 and health care providers.

498 (6) An insurer may not contract with a health care provider for treatment of illness or  
499 injury unless the health care provider is licensed to perform that treatment.

500 (7) (a) A health care provider or insurer may not discriminate against a preferred health  
501 care provider for agreeing to a contract under Subsection (1).

502 (b) Any health care provider licensed to treat any illness or injury within the scope of  
503 the health care provider's practice, who is willing and able to meet the terms and conditions  
504 established by the insurer for designation as a preferred health care provider, shall be able to  
505 apply for and receive the designation as a preferred health care provider. Contract terms and  
506 conditions may include reasonable limitations on the number of designated preferred health  
507 care providers based upon substantial objective and economic grounds, or expected use of  
508 particular services based upon prior provider-patient profiles.

509 (8) Upon the written request of a provider excluded from a provider contract, the  
510 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is  
511 based on the criteria set forth in Subsection (7)(b).

512 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and  
513 31A-22-618.

514 (10) Nothing in this section is to be construed as to require an insurer to offer a certain  
515 benefit or service as part of a health benefit plan.

516 (11) This section does not apply to catastrophic mental health coverage provided in  
517 accordance with Section 31A-22-625.

518 Section 4. Section **31A-22-618.5** is enacted to read:

519 **31A-22-618.5. Health plan offerings.**

520 (1) The purpose of this section is to increase the range of health benefit plans available  
521 in the small group, small employer group, large group, and individual insurance markets.

522 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance

523 Organizations and Limited Health Plans:

524 (a) shall offer to potential purchasers at least one health benefit plan that is subject to  
525 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;  
526 and

527 (b) may offer to a potential purchaser one or more health benefit plans that:

528 (i) are not subject to one or more of the following:

529 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

530 (B) the limitation on point of service products in Subsections 31A-8-408(3) through  
531 (6);

532 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in  
533 Section 31A-8-101; or

534 (D) coverage mandates enacted after January 1, 2009 that are not required by federal  
535 law; and

536 (ii) when offering a health plan under this section, provide coverage for an emergency  
537 medical condition as required by Section 31A-22-627 as follows:

538 (A) within the organization's service area, covered services shall include health care  
539 services from non-affiliated providers when medically necessary to stabilize an emergency  
540 medical condition; and

541 (B) outside the organization's service area, covered services shall include medically  
542 necessary health care services for the treatment of an emergency medical condition that are  
543 immediately required while the enrollee is outside the geographic limits of the organization's  
544 service area.

545 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health  
546 Maintenance Organizations and Limited Health Plans:

547 (a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that  
548 groups providers into the following reimbursement levels:

549 (i) tier one contracted providers;

550 (ii) tier two contracted providers who the insurer must reimburse at least 75% of tier  
551 one providers; and

552 (iii) one or more tiers of non-contracted providers; and

553 (b) may offer a health benefit plan that is not subject to Subsection 31A-22-617(9) and

554 Section 31A-22-618;

555 (c) beginning July 1, 2012 may offer products under Subsection (3)(a) that are not  
556 subject to Subsection 31A-22-617(2); and

557 (d) when offering a health plan under this Subsection (3), shall provide coverage of  
558 emergency care services as required by Section 31A-22-627 by providing coverage at a  
559 reimbursement level of at least 75% of tier one providers.

560 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under  
561 Subsection (2)(b).

562 (5) (a) Any difference in price between a health benefit plan offered under Subsections  
563 (2)(a) and (b) shall be based on actuarially sound data.

564 (b) Any difference in price between a health benefit plan offered under Subsections  
565 (3)(a) and (b) shall be based on actuarially sound data.

566 (6) Nothing in this section limits the number of health benefit plans that an insurer may  
567 offer.

568 Section 5. Section **31A-22-722** is amended to read:

569 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

570 (1) An insured has the right to extend the employee's coverage under the current  
571 employer's group policy for a period of [~~six~~] 12 months, except as provided in Subsection (2).

572 The right to extend coverage includes:

- 573 (a) voluntary termination;  
574 (b) involuntary termination;  
575 (c) retirement;  
576 (d) death;  
577 (e) divorce or legal separation;  
578 (f) loss of dependent status;  
579 (g) sabbatical;  
580 (h) any disability;  
581 (i) leave of absence; or  
582 (j) reduction of hours.

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

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

616 (4) The insurer shall provide the employee, spouse, or any eligible dependent the  
617 opportunity to extend the group coverage at the payment amount stated in [~~this~~] Subsection  
618 [~~(3)~~] (5) if:

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

621 (b) the employee or other individual eligible for extension contacts the insurer within  
622 60 days of coverage termination.

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

626 (6) Except as provided in this Subsection (6), the coverage extends without  
627 interruption for [~~six~~] 12 months and may not terminate if the terminated insured or, with  
628 respect to a minor, the parent or guardian of the terminated insured:

629 (a) elects to extend group coverage within 60 days of losing group coverage; and

630 (b) tenders the amount required to the employer or insurer.

631 (7) The insured's coverage may be terminated prior to [~~six~~] 12 months if the terminated  
632 insured:

633 (a) establishes residence outside of this state;

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

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

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

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

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

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

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

646 (a) for the balance of the period the terminated insured would have extended coverage

647 under the replaced group policy; and

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

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

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

654 (i) shall be sent first class mail to:

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

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

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

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

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

664 Section 6. Section **31A-22-723** is amended to read:

665 **31A-22-723. Group and blanket conversion coverage.**

666 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection  
667 (3), all policies of accident and health insurance offered on a group basis under this title, or  
668 Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that  
669 a person whose insurance under the group policy has been terminated is entitled to choose a  
670 converted individual policy [~~of similar accident and health insurance~~] in accordance with this  
671 section and Section 31A-22-724.

672 (2) A person who has lost group coverage may elect conversion coverage with the  
673 insurer that provided prior group coverage if the person:

674 (a) has been continuously covered for a period of [~~six~~] three months by the group  
675 policy or the group's preceding policies immediately prior to termination;

676 (b) has exhausted either:

677 (i) Utah mini-COBRA coverage as required in Section 31A-22-722 [~~or~~];

678           (ii) federal COBRA coverage; or  
679           (iii) alternative coverage under Section 31A-22-724;

680           (c) has not acquired or is not covered under any other group coverage that covers all  
681 preexisting conditions, including maternity, if the coverage exists; and

682           (d) resides in the insurer's service area.

683           (3) This section does not apply if the person's prior group coverage:

684           (a) is a stand alone policy that only provides one of the following:

685           (i) catastrophic benefits;

686           (ii) aggregate stop loss benefits;

687           (iii) specific stop loss benefits;

688           (iv) benefits for specific diseases;

689           (v) accidental injuries only;

690           (vi) dental; or

691           (vii) vision;

692           (b) is an income replacement policy;

693           (c) was terminated because the insured:

694           (i) failed to pay any required individual contribution;

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

696 or

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

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

699 31A-30-107(2)(a).

700           (4) (a) The employer shall provide written notification of the right to an individual  
701 conversion policy within 30 days of the insured's termination of coverage to:

702           (i) the terminated insured;

703           (ii) the ex-spouse; or

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

705           (A) the surviving spouse; and

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

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

708           (i) be sent by first class mail;

709 (ii) contain the name, address, and telephone number of the insurer that will provide  
710 the conversion coverage; and

711 (iii) be sent to the insured's last-known address as shown on the records of the  
712 employer of:

713 (A) the insured;

714 (B) the ex-spouse; and

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

716 (I) the surviving spouse; and

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

718 (5) (a) An insurer is not required to issue a converted policy which provides benefits in  
719 excess of those provided under the group policy from which conversion is made.

720 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health  
721 benefit plan, the employee or member ~~[must]~~ shall be offered;

722 (i) at least the basic benefit plan as provided in Section 31A-22-613.5 through  
723 December 31, 2009; and

724 (ii) beginning January 1, 2010, only the alternative coverage as provided in Section  
725 31A-22-724(1)(a).

726 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels  
727 provided under the group policy, the conversion policy may offer benefits which are  
728 substantially similar to those provided under the group policy.

729 (6) Written application for the converted policy shall be made and the first premium  
730 paid to the insurer no later than 60 days after termination of the group accident and health  
731 insurance.

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

733 (8) (a) The initial premium for the converted policy for the first 12 months and  
734 subsequent renewal premiums shall be determined in accordance with premium rates  
735 applicable to age, class of risk of the person, and the type and amount of insurance provided.

736 (b) The initial premium for the first 12 months may not be raised based on pregnancy  
737 of a covered insured.

738 (c) The premium for converted policies shall be payable monthly or quarterly as  
739 required by the insurer for the policy form and plan selected, unless another mode or premium



740 payment is mutually agreed upon.

741 (9) The converted policy becomes effective at the time the insurance under the group  
742 policy terminates.

743 (10) (a) A newly issued converted policy covers the employee or the member and must  
744 also cover all dependents covered by the group policy at the date of termination of the group  
745 coverage.

746 (b) The only dependents that may be added after the policy has been issued are children  
747 and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

748 (c) At the option of the insurer, a separate converted policy may be issued to cover any  
749 dependent.

750 (11) (a) To the extent the group policy provided maternity benefits, the conversion  
751 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group  
752 policy or the conversion policy until termination of a pregnancy that exists on the date of  
753 conversion if one of the following is pregnant on the date of the conversion:

- 754 (i) the insured;
- 755 (ii) a spouse of the insured; or
- 756 (iii) a dependent of the insured.

757 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs  
758 after the date of conversion.

759 (12) Except as provided in this Subsection (12), a converted policy is renewable with  
760 respect to all individuals or dependents at the option of the insured. An insured may be  
761 terminated from a converted policy for the following reasons:

- 762 (a) a dependent is no longer eligible under the policy;
- 763 (b) for a network plan, if the individual no longer lives, resides, or works in:
  - 764 (i) the insured's service area; or
  - 765 (ii) the area for which the covered carrier is authorized to do business;
- 766 (c) the individual fails to pay premiums or contributions in accordance with the terms  
767 of the converted policy, including any timeliness requirements;
- 768 (d) the individual performs an act or practice that constitutes fraud in connection with  
769 the coverage;
- 770 (e) the individual makes an intentional misrepresentation of material fact under the

771 terms of the coverage; or

772 (f) coverage is terminated uniformly without regard to any health status-related factor  
773 relating to any covered individual.

774 (13) Conditions pertaining to health may not be used as a basis for classification under  
775 this section.

776 Section 7. Section **31A-22-724** is enacted to read:

777 **31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**

778 (1) For purposes of this section, "alternative coverage" means:

779 (a) the high deductible or low deductible Utah NetCare Plan described in Subsection

780 (2) for conversion policies offered under Section 31A-22-723; and

781 (b) the high deductible and low deductible Utah NetCare Plans described in Subsection

782 (2) as an alternative to COBRA and mini-COBRA policies offered under Section 31A-22-722.

783 (2) The Utah NetCare Plans shall include:

784 (a) healthy lifestyle and wellness incentives;

785 (b) the benefits described in this Subsection (2) or at least the actuarial equivalent of

786 the benefits described in this Subsection (2);

787 (c) a lifetime maximum benefit per person of not less than \$1 million;

788 (d) an annual maximum benefit per person of not less than \$250,000;

789 (e) the following deductibles:

790 (i) for the low deductible plans:

791 (A) \$2,000 for an individual plan;

792 (B) \$4,000 for a two party plan; and

793 (C) \$6,000 for a family plan;

794 (ii) for the high deductible plans:

795 (A) \$4,000 for an individual plan;

796 (B) \$8,000 for a two party plan; and

797 (C) \$12,000 for a family plan;

798 (f) the following out-of-pocket maximum costs, including deductibles, copayments,

799 and coinsurance:

800 (i) for the low deductible plans:

801 (A) \$5,000 for an individual plan;

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

- 833 (i) Section 31A-22-610.1, Adoption indemnity benefits;
- 834 (ii) Section 31A-22-623, Inborn metabolic errors;
- 835 (iii) Section 31A-22-624, Primary care physicians;
- 836 (iv) Section 31A-22-626, Coverage of diabetes;
- 837 (v) Section 31A-22-628, Standing referral to a specialist; and
- 838 (vi) coverage mandates enacted after January 1, 2009 that are not required by federal
- 839 law.

840 (4) (a) Beginning January 1, 2010, and except as provided in Subsection (5), a person  
841 may elect alternative coverage under this section if the person:

- 842 (i) is eligible for continuation of employer group coverage under federal COBRA laws;
- 843 (ii) is eligible for continuation of employer group coverage under state mini-COBRA
- 844 under Section 31A-22-722; or
- 845 (iii) is eligible for a conversion to an individual plan after the exhaustion of benefits
- 846 under:

- 847 (A) alternative coverage elected in place of federal COBRA; or
- 848 (B) state mini-COBRA under Section 31A-22-722.

849 (b) The right to extend coverage under Subsection (4)(a) applies to any spouse or  
850 dependent coverages, including a surviving spouse or dependent whose coverage under the  
851 policy terminates by reason of the death of the employee or member.

852 (5) If a person elects federal COBRA coverage, or state mini-COBRA coverage under  
853 Section 31A-22-722, the person is not eligible to elect alternative coverage under this section  
854 until the person is eligible to convert coverage to an individual policy under the provisions of  
855 Section 31A-22-723 and Subsection (1)(a).

856 (6) (a) If the alternative coverage is selected as an alternative to COBRA or  
857 mini-COBRA under Section 31A-22-722, the provisions of Section 31A-22-722 apply to the  
858 alternative coverage.

859 (b) If the alternative coverage is selected as a conversion policy under Section  
860 31A-22-723, the provisions of Section 31A-22-723 apply.

861 (7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to  
862 September 1, 2009, file an alternative coverage policy with the department in accordance with  
863 Sections 31A-21-201 and 31A-21-201.1.

864 (b) The department shall, by November 1, 2009, adopt administrative rules in  
865 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to develop a  
866 model letter for employers to use to notify an employee of the employee's options for  
867 alternative coverage.

868 Section 8. Section **31A-23a-401** is amended to read:

869 **31A-23a-401. Disclosure of conflicting interests.**

870 (1) (a) Except as provided under Subsection (1)(b):

871 (i) a licensee under this chapter may not act in the same or any directly related  
872 transaction as:

873 (A) a producer for the insured or consultant; and

874 (B) producer for the insurer; and

875 (ii) a producer for the insured or consultant may not recommend or encourage the  
876 purchase of insurance from or through an insurer or other producer:

877 (A) of which the producer for the insured or consultant or producer for the insured's or  
878 consultant's spouse is an owner, executive, or employee; or

879 (B) to which the producer for the insured or consultant has the type of relation that a  
880 material benefit would accrue to the producer for the insured or consultant or spouse as a result  
881 of the purchase.

882 (b) Subsection (1)(a) does not apply if the following three conditions are met:

883 (i) Prior to performing the consulting services, the producer for the insured or  
884 consultant shall disclose to the client, prominently, in writing:

885 (A) the producer for the insured's or consultant's interest as a producer for the insurer,  
886 or the relationship to an insurer or other producer; and

887 (B) that as a result of those interests, the producer for the insured's or the consultant's  
888 recommendations should be given appropriate scrutiny.

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

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

894 (2) A licensee under this chapter may not act as to the same client as both a producer

895 for the insurer and a producer for the insured without the client's prior written consent based on  
896 full disclosure.

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

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

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

905 **31A-23a-501. Licensee compensation.**

906 (1) As used in this section:

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

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

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

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

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

917 (B) received from:

918 (I) an insurer; or

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

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

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

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

925 (c) (i) "Customer" means:

926 (A) the person signing the application or submission for insurance; or  
927 (B) the authorized representative of the insured actually negotiating the placement of  
928 insurance with the producer.

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

930 (A) an employee benefit plan; or

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

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

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

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

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

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

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

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

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

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

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

949 (b) Noncommission compensation shall be:

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

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

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

956 (d) All accounting records relating to noncommission compensation shall be

957 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

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

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

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

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

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

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

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

971 (c) The following additional noncommission compensation is authorized:

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

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

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

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

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

984 (i) a producer;

985 (ii) an affiliate of a producer; or

986 (iii) a consultant.

987 (b) Beginning January 1, 2010, in addition to any other disclosures required by this



988 section, a producer may not accept or receive any compensation from an insurer or third party  
989 administrator for the placement of health care insurance unless prior to the customer's purchase  
990 of health care insurance the producer:

991 (i) except as provided in Subsection (4)(c), discloses in writing to the customer that the  
992 producer will receive compensation from the insurer or third party administrator for the  
993 placement of insurance, including the amount or type of compensation known to the producer  
994 at the time of the disclosure; and

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

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

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

1000 (c) If the compensation to the producer from an insurer or third party administrator is  
1001 for the renewal of health care insurance, once the producer has made an initial disclosure that  
1002 complies with Subsection (4)(b), the producer does not have to disclose compensation received  
1003 for the subsequent yearly renewals in accordance with Subsection (4)(b) until the renewal  
1004 period immediately following 36 months after the initial disclosure.

1005 (d) (i) A copy of the signed acknowledgment required by Subsection (4)(b) must be  
1006 maintained by the licensee who collects or receives any part of the compensation from an  
1007 insurer or third party administrator in a manner that facilitates an audit.

1008 (ii) The standard application developed in accordance with Section 31A-22-635 shall  
1009 include a place for a producer to provide the disclosure required by Subsection (4), and if  
1010 completed, shall satisfy the requirement of Subsection (4)(d)(i).

1011 (e) Subsection (4)(b)(ii) does not apply to:

1012 (i) a person licensed as a producer who acts only as an intermediary between an insurer  
1013 and the customer's producer, including a managing general agent; or

1014 (ii) the placement of insurance in a secondary or residual market.

1015 ~~[(4)]~~ (5) This section does not alter the right of any licensee to recover from an insured  
1016 the amount of any premium due for insurance effected by or through that licensee or to charge  
1017 a reasonable rate of interest upon past-due accounts.

1018 ~~[(5)]~~ (6) This section does not apply to bail bond producers or bail enforcement agents

1019 as defined in Section 31A-35-102.

1020 Section 10. Section **31A-30-102** is amended to read:

1021 **Part 1. Individual and Small Employer Group**

1022 **31A-30-102. Purpose statement.**

1023 The purpose of this chapter is to:

1024 (1) prevent abusive rating practices;

1025 (2) require disclosure of rating practices to purchasers;

1026 (3) establish rules regarding:

1027 (a) a universal individual and small group application; and

1028 (b) renewability of coverage;

1029 (4) improve the overall fairness and efficiency of the individual and small group

1030 insurance market; [~~and~~]

1031 (5) provide increased access for individuals and small employers to health insurance[-];

1032 and

1033 (6) provide an employer with the opportunity to establish a defined contribution

1034 arrangement for an employee to purchase a health benefit plan through the Internet portal

1035 created by Section 63M-1-2504.

1036 Section 11. Section **31A-30-103** is amended to read:

1037 **31A-30-103. Definitions.**

1038 As used in this chapter:

1039 (1) "Actuarial certification" means a written statement by a member of the American

1040 Academy of Actuaries or other individual approved by the commissioner that a covered carrier

1041 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,

1042 including review of the appropriate records and of the actuarial assumptions and methods used

1043 by the covered carrier in establishing premium rates for applicable health benefit plans.

1044 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly

1045 through one or more intermediaries, controls or is controlled by, or is under common control

1046 with, a specified entity or person.

1047 (3) "Base premium rate" means, for each class of business as to a rating period, the

1048 lowest premium rate charged or that could have been charged under a rating system for that

1049 class of business by the covered carrier to covered insureds with similar case characteristics for

1050 health benefit plans with the same or similar coverage.

1051 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under  
1052 [~~Subsection~~] Section 31A-22-613.5[(2)].

1053 (5) "Carrier" means any person or entity that provides health insurance in this state  
1054 including:

1055 (a) an insurance company;

1056 (b) a prepaid hospital or medical care plan;

1057 (c) a health maintenance organization;

1058 (d) a multiple employer welfare arrangement; and

1059 (e) any other person or entity providing a health insurance plan under this title.

1060 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means  
1061 demographic or other objective characteristics of a covered insured that are considered by the  
1062 carrier in determining premium rates for the covered insured.

1063 (b) "Case characteristics" do not include:

1064 (i) duration of coverage since the policy was issued;

1065 (ii) claim experience; and

1066 (iii) health status.

1067 (7) "Class of business" means all or a separate grouping of covered insureds  
1068 established under Section 31A-30-105.

1069 (8) "Conversion policy" means a policy providing coverage under the conversion  
1070 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

1071 (9) "Covered carrier" means any individual carrier or small employer carrier subject to  
1072 this chapter.

1073 (10) "Covered individual" means any individual who is covered under a health benefit  
1074 plan subject to this chapter.

1075 (11) "Covered insureds" means small employers and individuals who are issued a  
1076 health benefit plan that is subject to this chapter.

1077 (12) "Dependent" means an individual to the extent that the individual is defined to be  
1078 a dependent by:

1079 (a) the health benefit plan covering the covered individual; and

1080 (b) Chapter 22, Part 6, Accident and Health Insurance.

1081 (13) "Established geographic service area" means a geographical area approved by the  
1082 commissioner within which the carrier is authorized to provide coverage.

1083 (14) "Index rate" means, for each class of business as to a rating period for covered  
1084 insureds with similar case characteristics, the arithmetic average of the applicable base  
1085 premium rate and the corresponding highest premium rate.

1086 (15) "Individual carrier" means a carrier that provides coverage on an individual basis  
1087 through a health benefit plan regardless of whether:

1088 (a) coverage is offered through:

1089 (i) an association;

1090 (ii) a trust;

1091 (iii) a discretionary group; or

1092 (iv) other similar groups; or

1093 (b) the policy or contract is situated out-of-state.

1094 (16) "Individual conversion policy" means a conversion policy issued to:

1095 (a) an individual; or

1096 (b) an individual with a family.

1097 (17) "Individual coverage count" means the number of natural persons covered under a  
1098 carrier's health benefit products that are individual policies.

1099 (18) "Individual enrollment cap" means the percentage set by the commissioner in  
1100 accordance with Section 31A-30-110.

1101 (19) "New business premium rate" means, for each class of business as to a rating  
1102 period, the lowest premium rate charged or offered, or that could have been charged or offered,  
1103 by the carrier to covered insureds with similar case characteristics for newly issued health  
1104 benefit plans with the same or similar coverage.

1105 (20) "Plan year" means the year that is designated as the plan year in the plan document  
1106 of a group health plan, except that if the plan document does not designate a plan year or if  
1107 there is not a plan document, the plan year is:

1108 (a) the deductible or limit year used under the plan;

1109 (b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

1110 (c) if the plan does not impose a deductible or limit on a yearly basis and either the  
1111 plan is not insured or the insurance policy is not renewed on an annual basis, the employer's

1112 taxable year; or

1113 (d) in any case not described in Subsections (20)(a) through (c), the calendar year.

1114 (21) "Preexisting condition" is as defined in Section 31A-1-301.

1115 (22) "Premium" means all monies paid by covered insureds and covered individuals as  
1116 a condition of receiving coverage from a covered carrier, including any fees or other  
1117 contributions associated with the health benefit plan.

1118 (23) (a) "Rating period" means the calendar period for which premium rates  
1119 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1120 (b) A covered carrier may not have:

1121 (i) more than one rating period in any calendar month; and

1122 (ii) no more than 12 rating periods in any calendar year.

1123 (24) "Resident" means an individual who has resided in this state for at least 12  
1124 consecutive months immediately preceding the date of application.

1125 (25) "Short-term limited duration insurance" means a health benefit product that:

1126 (a) is not renewable; and

1127 (b) has an expiration date specified in the contract that is less than 364 days after the  
1128 date the plan became effective.

1129 (26) "Small employer carrier" means a carrier that provides health benefit plans  
1130 covering eligible employees of one or more small employers in this state, regardless of  
1131 whether:

1132 (a) coverage is offered through:

1133 (i) an association;

1134 (ii) a trust;

1135 (iii) a discretionary group; or

1136 (iv) other similar grouping; or

1137 (b) the policy or contract is situated out-of-state.

1138 (27) "Uninsurable" means an individual who:

1139 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the  
1140 underwriting criteria established in Subsection 31A-29-111(5); or

1141 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

1142 (ii) has a condition of health that does not meet consistently applied underwriting

1143 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)  
1144 and (j) for which coverage the applicant is applying.

1145 (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for  
1146 purposes of this formula:

1147 (a) "CI" means the carrier's individual coverage count as of December 31 of the  
1148 preceding year; and

1149 (b) "UC" means the number of uninsurable individuals who were issued an individual  
1150 policy on or after July 1, 1997.

1151 Section 12. Section **31A-30-104** is amended to read:

1152 **31A-30-104. Applicability and scope.**

1153 (1) This chapter applies to any:

1154 (a) health benefit plan that provides coverage to:

1155 (i) individuals;

1156 (ii) small employers; or

1157 (iii) both Subsections (1)(a)(i) and (ii); or

1158 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and  
1159 31A-30-107.5.

1160 (2) This chapter applies to a health benefit plan that provides coverage to small  
1161 employers or individuals regardless of:

1162 (a) whether the contract is issued to:

1163 (i) an association;

1164 (ii) a trust;

1165 (iii) a discretionary group; or

1166 (iv) other similar grouping; or

1167 (b) the situs of delivery of the policy or contract.

1168 (3) This chapter does not apply to:

1169 (a) a large employer health benefit plan, except as specifically provided in Part 2.

1170 Defined Contribution Arrangements;

1171 (b) short-term limited duration health insurance; or

1172 (c) federally funded or partially funded programs.

1173 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

1174 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax  
1175 return shall be treated as one carrier; and

1176 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health  
1177 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated  
1178 carriers were issued by one carrier.

1179 (b) Upon a finding of the commissioner, an affiliated carrier that is a health  
1180 maintenance organization having a certificate of authority under this title may be considered to  
1181 be a separate carrier for the purposes of this chapter.

1182 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined  
1183 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding  
1184 arrangements with respect to health benefit plans delivered or issued for delivery to covered  
1185 insureds in this state if the ceding arrangements would result in less than 50% of the insurance  
1186 obligation or risk for the health benefit plans being retained by the ceding carrier.

1187 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the  
1188 insurance obligation or risk with respect to one or more health benefit plans delivered or issued  
1189 for delivery to covered insureds in this state.

1190 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal  
1191 Labor Management Relations Act, or a carrier with the written authorization of such a trust,  
1192 may make a written request to the commissioner for a waiver from the application of any of the  
1193 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the  
1194 trust.

1195 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a  
1196 waiver if the commissioner finds that application with respect to the trust would:

1197 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;  
1198 and

1199 (ii) require significant modifications to one or more collective bargaining arrangements  
1200 under which the trust is established or maintained.

1201 (c) A waiver granted under this Subsection (5) may not apply to an individual if the  
1202 person participates in a Taft Hartley trust as an associate member of any employee  
1203 organization.

1204 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and

1205 31A-30-111 apply to:

1206 (a) any insurer engaging in the business of insurance related to the risk of a small  
1207 employer for medical, surgical, hospital, or ancillary health care expenses of the small  
1208 employer's employees provided as an employee benefit; and

1209 (b) any contract of an insurer, other than a workers' compensation policy, related to the  
1210 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the  
1211 small employer's employees provided as an employee benefit.

1212 (7) The commissioner may make rules requiring that the marketing practices be  
1213 consistent with this chapter for:

1214 (a) a small employer carrier;

1215 (b) a small employer carrier's agent;

1216 (c) an insurance producer; and

1217 (d) an insurance consultant.

1218 Section 13. Section **31A-30-107** is amended to read:

1219 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**  
1220 **nonrenewal.**

1221 (1) Except as otherwise provided in this section, a small employer health benefit plan is  
1222 renewable and continues in force:

1223 (a) with respect to all eligible employees and dependents; and

1224 (b) at the option of the plan sponsor.

1225 (2) A small employer health benefit plan may be discontinued or nonrenewed:

1226 (a) for a network plan, if:

1227 (i) there is no longer any enrollee under the group health plan who lives, resides, or  
1228 works in:

1229 (A) the service area of the covered carrier; or

1230 (B) the area for which the covered carrier is authorized to do business; and

1231 (ii) in the case of the small employer market, the small employer carrier applies the  
1232 same criteria the small employer carrier would apply in denying enrollment in the plan under  
1233 Subsection 31A-30-108(7); or

1234 (b) for coverage made available in the small or large employer market only through an  
1235 association, if:



- 1236 (i) the employer's membership in the association ceases; and  
1237 (ii) the coverage is terminated uniformly without regard to any health status-related  
1238 factor relating to any covered individual.
- 1239 (3) A small employer health benefit plan may be discontinued if:
- 1240 (a) a condition described in Subsection (2) exists;
- 1241 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay  
1242 premiums or contributions in accordance with the terms of the contract;
- 1243 (c) the plan sponsor:
- 1244 (i) performs an act or practice that constitutes fraud; or  
1245 (ii) makes an intentional misrepresentation of material fact under the terms of the  
1246 coverage;
- 1247 (d) the covered carrier:
- 1248 (i) elects to discontinue offering a particular small employer health benefit product  
1249 delivered or issued for delivery in this state; and
- 1250 (ii) (A) provides notice of the discontinuation in writing:
- 1251 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and  
1252 (II) at least 90 days before the date the coverage will be discontinued;
- 1253 (B) provides notice of the discontinuation in writing:
- 1254 (I) to the commissioner; and  
1255 (II) at least three working days prior to the date the notice is sent to the affected plan  
1256 sponsors, employees, and dependents of the plan sponsors or employees;
- 1257 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all  
1258 other small employer health benefit products currently being offered by the small employer  
1259 carrier in the market; and
- 1260 (D) in exercising the option to discontinue that product and in offering the option of  
1261 coverage in this section, acts uniformly without regard to:
- 1262 (I) the claims experience of a plan sponsor;
- 1263 (II) any health status-related factor relating to any covered participant or beneficiary; or  
1264 (III) any health status-related factor relating to any new participant or beneficiary who  
1265 may become eligible for the coverage; or
- 1266 (e) the covered carrier:

- 1267 (i) elects to discontinue all of the covered carrier's small employer health benefit plans  
1268 in:
- 1269 (A) the small employer market;
  - 1270 (B) the large employer market; or
  - 1271 (C) both the small employer and large employer markets; and
- 1272 (ii) (A) provides notice of the discontinuation in writing:
- 1273 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
  - 1274 (II) at least 180 days before the date the coverage will be discontinued;
- 1275 (B) provides notice of the discontinuation in writing:
- 1276 (I) to the commissioner in each state in which an affected insured individual is known  
1277 to reside; and
  - 1278 (II) at least 30 working days prior to the date the notice is sent to the affected plan  
1279 sponsors, employees, and the dependents of the plan sponsors or employees;
- 1280 (C) discontinues and nonrenews all plans issued or delivered for issuance in the  
1281 market; and
- 1282 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- 1283 (4) A small employer health benefit plan may be discontinued or nonrenewed:
- 1284 (a) if a condition described in Subsection (2) exists; or
  - 1285 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's  
1286 employer contribution requirements.
- 1287 (5) A small employer health benefit plan may be nonrenewed:
- 1288 (a) if a condition described in Subsection (2) exists; or
  - 1289 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's  
1290 minimum participation requirements.
- 1291 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be  
1292 discontinued if after issuance of coverage the eligible employee:
- 1293 (i) engages in an act or practice that constitutes fraud in connection with the coverage;  
1294 or
  - 1295 (ii) makes an intentional misrepresentation of material fact in connection with the  
1296 coverage.
- 1297 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

- 1298 (i) 12 months after the date of discontinuance; and  
1299 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
1300 to reenroll.
- 1301 (c) At the time the eligible employee's coverage is discontinued under Subsection  
1302 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when  
1303 coverage is discontinued.
- 1304 (d) An eligible employee may not be discontinued under this Subsection (6) because of  
1305 a fraud or misrepresentation that relates to health status.
- 1306 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to  
1307 the employer:
- 1308 (a) with respect to coverage provided to an employer member of the association; and  
1309 (b) if the small employer health benefit plan is made available by a covered carrier in  
1310 the employer market only through:
- 1311 (i) an association;  
1312 (ii) a trust; or  
1313 (iii) a discretionary group.
- 1314 (8) A covered carrier may modify a small employer health benefit plan only:
- 1315 (a) at the time of coverage renewal; and  
1316 (b) if the modification is effective uniformly among all plans with that product.
- 1317 Section 14. Section **31A-30-109** is amended to read:
- 1318 **31A-30-109. Health benefit plan choices.**
- 1319 (1) An individual carrier who offers individual coverage pursuant to Section  
1320 31A-30-108;
- 1321 (a) shall offer in the individual market under this chapter:
- 1322 (i) a choice of coverage that is at least equal to or greater than basic coverage[-]; and  
1323 (ii) beginning January 1, 2010, the Utah NetCare Plan described in Subsection  
1324 31A-22-724(2); and
- 1325 (b) may offer a choice of coverage that:
- 1326 (i) costs less than or equal to the plan described in Subsection (1)(a)(ii); and  
1327 (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).
- 1328 (2) Beginning January 1, 2010, a small employer group carrier who offers small

1329 employer group coverage pursuant to Section 31A-30-108:

1330 (a) shall offer in the small employer group market under this part:

1331 (i) a choice of coverage that is at least equal to or greater than basic coverage; and

1332 (ii) coverage under the Utah NetCare Plan described in Section 31A-22-724; and

1333 (b) may offer in the small employer group market under this part, a choice of coverage

1334 that:

1335 (i) costs less than or equal to the coverage in Subsection (2)(a); and

1336 (ii) excludes some or all of the mandates described in Subsection 31A-22-724(3).

1337 (3) Nothing in this section limits the number of health benefit plans an insurer may

1338 offer.

1339 Section 15. Section **31A-30-112** is amended to read:

1340 **31A-30-112. Employee participation levels.**

1341 (1) (a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement  
1342 used by a covered carrier in determining whether to provide coverage to a small employer,  
1343 including a requirement for minimum participation of eligible employees and minimum  
1344 employer contributions, shall be applied uniformly among all small employers with the same  
1345 number of eligible employees applying for coverage or receiving coverage from the covered  
1346 carrier.

1347 (b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require  
1348 that a small employer have a minimum of two eligible employees to meet participation  
1349 requirements.

1350 (2) A covered carrier may not increase a requirement for minimum employee  
1351 participation or a requirement for minimum employer contribution applicable to a small  
1352 employer at any time after the small employer is accepted for coverage.

1353 Section 16. Section **31A-30-201** is enacted to read:

1354 **Part 2. Defined Contribution Arrangements**

1355 **31A-30-201. Title.**

1356 This part is known as "Defined Contribution Arrangements."

1357 Section 17. Section **31A-30-202** is enacted to read:

1358 **31A-30-202. Definitions.**

1359 For purposes of this part:

- 1360           (1) "Defined contribution arrangement" means a defined contribution arrangement  
1361 employer group health benefit plan that:
- 1362           (a) complies with this part; and  
1363           (b) is sold through the Internet portal in accordance with Title 63M, Chapter 1, Part 25,  
1364 Health System Reform Act.
- 1365           (2) "Health reimbursement arrangement" means an employer provided health  
1366 reimbursement arrangement in which reimbursements for medical care expenses are excluded  
1367 from an employee's gross income under the Internal Revenue Code.
- 1368           (3) "Producer" is as defined in Subsection 31A-23a-501(4)(a).
- 1369           (4) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies  
1370 under Section 125, Internal Revenue Code which permits an employee to contribute pre-tax  
1371 dollars to a health benefit plan.
- 1372           (5) "Small employer" is defined in Section 31A-1-301.
- 1373           Section 18. Section **31A-30-203** is enacted to read:
- 1374           **31A-30-203. Eligibility for defined contribution arrangement market --**  
1375 **Enrollment.**
- 1376           (1) (a) Beginning January 1, 2010, and during the open enrollment period described in  
1377 Section 31A-30-208, an eligible small employer may choose to participate in a defined  
1378 contribution arrangement.
- 1379           (b) Beginning January 1, 2012, and during the open enrollment period described in  
1380 Section 31A-30-208, an eligible large employer may choose to participate in a defined  
1381 contribution arrangement.
- 1382           (c) Defined contribution arrangement health benefit plans are employer group health  
1383 plans individually selected by an employee of an employer.
- 1384           (2) (a) Participating insurers:
- 1385           (i) shall offer to accept all eligible employees of an employer described in Subsection  
1386 (1), and their dependents at the same level of benefits as anyone else who has the same health  
1387 benefit plan in the defined contribution arrangement market; and
- 1388           (ii) may not impose a premium surcharge under Section 31A-30-106.7 in the defined  
1389 contribution market.
- 1390           (b) A participating insurer may:

1391 (i) request an employer to submit a copy of the employer's quarterly wage list to  
1392 determine whether the employees for whom coverage is provided or requested are bona fide  
1393 employees of the employer; and

1394 (ii) deny or terminate coverage if the employer refuses to provide documentation  
1395 requested under Subsection (2)(b)(i).

1396 Section 19. Section **31A-30-204** is enacted to read:

1397 **31A-30-204. Employer responsibilities -- Defined contribution arrangements.**

1398 (1) (a) (i) An employer described in Subsection 31A-30-203(1) that chooses to  
1399 participate in a defined contribution arrangement may not offer a major medical health benefit  
1400 plan that is not a part of the defined contribution arrangement to an employee.

1401 (ii) Subsection (1)(a)(i) does not prohibit the offer of supplemental or limited benefit  
1402 policies such as dental or vision coverage, or other types of federally qualified savings accounts  
1403 for health care expenses.

1404 (b) (i) To the extent permitted by the risk adjustment plan adopted under Section  
1405 31A-42-202, the employer reserves the right to determine:

1406 (A) the criteria for employee eligibility, enrollment, and participation in the employer's  
1407 health benefit plan; and

1408 (B) the amount of the employer's contribution to that plan.

1409 (ii) The determinations made under Subsection (1)(b) may only be changed during  
1410 periods of open enrollment.

1411 (2) An employer that chooses to establish a defined contribution arrangement to  
1412 provide a health benefit plan for its employees shall:

1413 (a) establish a mechanism for its employees to use pre-tax dollars to purchase a health  
1414 benefit plan from the defined contribution arrangement market on the Internet portal created in  
1415 Section 63M-1-2504, which may include:

1416 (i) a health reimbursement arrangement;

1417 (ii) a Section 125 Cafeteria plan; or

1418 (iii) another plan or arrangement similar to Subsection (2)(a)(i) or (ii) which is  
1419 excluded or deducted from gross income under the Internal Revenue Code;

1420 (b) by November 10 of the open enrollment period:

1421 (i) inform each employee of the health benefit plan the employer has selected as the

1422 default health benefit plan for the employer group;

1423 (ii) offer each employee a choice of any of the health benefit plans available through  
1424 the defined contribution arrangement market on the Internet portal; and

1425 (iii) notify the employee that the employee will be enrolled in the default health benefit  
1426 plan selected by the employer and payroll deductions initiated for premium payments, unless  
1427 the employee, prior to November 25 of the open enrollment period:

1428 (A) notifies the employer that the employee has selected a different health benefit plan  
1429 available through the defined contribution arrangement in the Internet portal;

1430 (B) provides proof of coverage from another health benefit plan; or

1431 (C) specifically declines coverage in a health benefit plan.

1432 (3) An employer shall enroll an employee in the default health benefit plan selected by  
1433 the employer if the employee does not make one of the choices described in Subsection  
1434 (2)(b)(ii) prior to November 25 of the open enrollment period.

1435 (4) The employer's notice to the employee under Subsection (2)(b)(iii) shall inform the  
1436 employee that the failure to act under Subsections (2)(b)(iii)(A) through (C) is considered an  
1437 affirmative election under pre-tax payroll deductions for the employer to begin payroll  
1438 deductions for health benefit plan premiums.

1439 Section 20. Section **31A-30-205** is enacted to read:

1440 **31A-30-205. Health benefit plans offered in the defined contribution market.**

1441 (1) An insurer who chooses to offer a health benefit plan in the defined contribution  
1442 market must offer the following:

1443 (a) one health benefit plan that:

1444 (i) is a federally qualified high deductible health plan;

1445 (ii) has the lowest deductible permitted for a federally qualified high deductible health  
1446 plan as adjusted by federal law; and

1447 (iii) does not exceed annual out-of-pocket maximum equal to three times the amount of  
1448 the annual deductible; and

1449 (b) one health benefit plan with benefits that have an actuarial value at least 15%  
1450 greater than the plan described in Subsection (1)(a).

1451 (2) The provisions of Subsection (1) do not limit the number of health benefit plans an  
1452 insurer may offer in the defined contribution market. An insurer who offers the health benefit

1453 plans required by Subsection (1) may also offer any other health benefit plan in the defined  
1454 contribution market if the health benefit plan provides benefits that are actuarially richer than  
1455 the benefits required in Subsection (1)(a).

1456 Section 21. Section **31A-30-206** is enacted to read:

1457 **31A-30-206. Minimum participation and contribution levels -- Premium**  
1458 **payments.**

1459 An insurer who offers a health benefit plan for which an employer has established a  
1460 defined contribution arrangement under the provisions of this part:

1461 (1) shall not:

1462 (a) establish an employer minimum contribution level for the health benefit plan  
1463 premium under Section 31A-30-112, or any other law; or

1464 (b) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to  
1465 maintain a minimum employer contribution level;

1466 (2) shall accept premium payments for an enrollee from multiple sources through the  
1467 Internet portal, including:

1468 (a) government assistance programs;

1469 (b) contributions from a Section 125 Cafeteria plan, a health reimbursement  
1470 arrangement, or other qualified mechanism for pre-tax payments established by any employer  
1471 of the enrollee;

1472 (c) contributions from a Section 125 Cafeteria plan, a health reimbursement  
1473 arrangement, or other qualified mechanism for pre-tax payments established by an employer of  
1474 a spouse or dependent of the enrollee; and

1475 (d) contributions from private sources of premium assistance; and

1476 (3) may require, as a condition of coverage, a minimum participation level for eligible  
1477 employees of an employer, which for purposes of the defined contribution arrangement market  
1478 may not exceed 75% participation.

1479 Section 22. Section **31A-30-207** is enacted to read:

1480 **31A-30-207. Rating and underwriting restrictions for defined contribution**  
1481 **market.**

1482 (1) The rating and underwriting restrictions for the defined contribution market shall be  
1483 established in accordance with the plan adopted under Chapter 42, Defined Contribution Risk



1484 Adjuster Act, and shall apply to employers who participate in the defined contribution  
1485 arrangement market.

1486 (2) All insurers who participate in the defined contribution market must participate in  
1487 the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster  
1488 Act.

1489 Section 23. Section **31A-30-208** is enacted to read:

1490 **31A-30-208. Enrollment Periods for the Defined Contribution Market.**

1491 (1) From November 1 to November 30 of each year an insurer offering a product in the  
1492 defined contribution market shall administer an open enrollment period for plans effective  
1493 January 1 following the November open enrollment period, during which an eligible employee  
1494 may enroll in a health benefit plan offered through the defined contribution market and may not  
1495 be declined coverage.

1496 (2) (a) Except as provided in Subsection (4), the period of open enrollment is the time  
1497 in which an insurer may:

1498 (i) enter or exit the defined contribution market;

1499 (ii) offer new or modify existing products in the defined contribution market; or

1500 (iii) withdraw products from the defined contribution market.

1501 (b) Ninety days prior to an open enrollment period under Subsection (1), an insurer  
1502 shall notify the Internet portal and the risk adjuster board created in Chapter 42, Defined  
1503 Contribution Risk Adjuster Act, regarding any of the events described in Subsection (2)(a).

1504 (3) An eligible employee may enroll in a health benefit plan offered in the defined  
1505 contribution market and may not be declined coverage, at a time other than the annual open  
1506 enrollment period for any of the circumstances recognized as permissible under federal tax law,  
1507 provided the individual does so within 63 days of the permissible circumstance.

1508 (4) When an insurer elects to participate in the defined contribution market, the insurer  
1509 shall participate in the defined contribution market for no less than two years.

1510 Section 24. Section **31A-42-101** is enacted to read:

## 1511 **CHAPTER 42. DEFINED CONTRIBUTION RISK ADJUSTER ACT**

### 1512 **Part 1. General Provisions**

1513 **31A-42-101. Title.**

1514 This chapter is known as the "Defined Contribution Risk Adjuster Act."

1515 Section 25. Section **31A-42-102** is enacted to read:

1516 **31A-42-102. Definitions.**

1517 As used in this chapter:

1518 (1) "Board" means the board of directors of the Utah Defined Contribution Risk

1519 Adjuster created in Section 31A-42-201.

1520 (2) "Risk adjuster" means the defined contribution risk adjustment mechanism created

1521 in Section 31A-42-201.

1522 Section 26. Section **31A-42-103** is enacted to read:

1523 **31A-42-103. Applicability and scope.**

1524 This chapter applies to a carrier as defined in Section 31A-30-103 who offers a health

1525 benefit plan in a defined contribution arrangement under Chapter 30, Part 2, Defined

1526 Contribution Arrangements.

1527 Section 27. Section **31A-42-201** is enacted to read:

1528 **Part 2. Creation of Risk Adjuster Mechanism**

1529 **31A-42-201. Creation of defined contribution market risk adjuster mechanism --**

1530 **Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.**

1531 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity  
1532 within the Insurance Department.

1533 (2) (a) The risk adjuster shall be under the direction of a board of directors composed  
1534 of up to nine members described in Subsection (2)(b).

1535 (b) The following directors shall be appointed by the governor with the consent of the  
1536 Senate:

1537 (i) at least three, but up to five directors with actuarial experience who represent  
1538 insurance carriers:

1539 (A) that are participating or have committed to participate in the defined contribution  
1540 arrangement market in the state; and

1541 (B) including at least one and up to two directors who represent a carrier that has a  
1542 small percentage of lives in the defined contribution market;

1543 (ii) one director who represents either an individual employee or employer participant  
1544 in the defined contribution market;

1545 (iii) one director appointed by the governor to represent the Office of Consumer Health

1546 Services within the Governor's Office of Economic Development;

1547 (iv) one director representing the Public Employee's Health Benefit Program with  
1548 actuarial experience, chosen by the director of the Public Employee's Health Benefit Program  
1549 who shall serve as an ex officio member; and

1550 (v) the commissioner or a representative from the department with actuarial experience  
1551 appointed by the commissioner, who will only have voting privileges in the event of a tie vote.

1552 (3) (a) Except as required by Subsection (3)(b), as terms of current board members  
1553 appointed by the governor expire, the governor shall appoint each new member or reappointed  
1554 member to a four-year term.

1555 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the  
1556 time of appointment or reappointment, adjust the length of terms to ensure that the terms of  
1557 board members are staggered so that approximately half of the board is appointed every two  
1558 years.

1559 (4) When a vacancy occurs in the membership for any reason, the replacement shall be  
1560 appointed for the unexpired term in the same manner as the original appointment was made.

1561 (5) (a) Members who are not government employees shall receive no compensation or  
1562 benefits for the members' services.

1563 (b) A state government member who is a member because of the member's state  
1564 government position may not receive per diem or expenses for the member's service.

1565 (6) The board shall elect annually a chair and vice chair from its membership.

1566 (7) Six board members are a quorum for the transaction of business.

1567 (8) The action of a majority of the members of the quorum is the action of the board.

1568 Section 28. Section **31A-42-202** is enacted to read:

1569 **31A-42-202. Contents of plan.**

1570 (1) The board shall submit a plan of operation for the risk adjuster to the  
1571 commissioner. The plan shall:

1572 (a) establish the methodology for implementing Subsection (2) for the defined  
1573 contribution arrangement market established under Chapter 30, Part 2, Defined Contribution

1574 Arrangements;

1575 (b) establish regular times and places for meetings of the board;

1576 (c) establish procedures for keeping records of all financial transactions and for

1577 sending annual fiscal reports to the commissioner;  
1578 (d) contain additional provisions necessary and proper for the execution of the powers  
1579 and duties of the risk adjuster; and  
1580 (e) establish procedures in compliance with Title 63A, Utah Administrative Services  
1581 Code, to pay for administrative expenses incurred.  
1582 (2) (a) The plan adopted by the board for the defined contribution arrangement market  
1583 shall include:  
1584 (i) parameters an employer may use to designate eligible employees for the defined  
1585 contribution arrangement market; and  
1586 (ii) underwriting mechanisms and employer eligibility guidelines:  
1587 (A) consistent with the federal Health Insurance Portability and Accountability Act;  
1588 and  
1589 (B) necessary to protect insurance carriers from adverse selection in the defined  
1590 contribution market.  
1591 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a  
1592 qualified individual are determined, including:  
1593 (i) the identification of an initial rate for a qualified individual based on:  
1594 (A) standardized age bands submitted by participating insurers; and  
1595 (B) wellness incentives for the individual as permitted by federal law; and  
1596 (ii) the identification of a group risk factor to be applied to the initial age rate of a  
1597 qualified individual based on the health conditions of all qualified individuals in the same  
1598 employer group and, for small employers, in accordance with Sections 31A-30-105 and  
1599 31A-30-106.  
1600 (c) The plan adopted under Subsection (2)(a) shall outline how:  
1601 (i) premium contributions for qualified individuals shall be submitted to the Internet  
1602 portal in the amount determined under Subsection (2)(b); and  
1603 (ii) the Internet portal shall distribute premiums to the insurers selected by qualified  
1604 individuals within an employer group based on each individual's health risk factor determined  
1605 in accordance with the plan.  
1606 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting  
1607 risk between insurers that:

- 1608 (i) identifies health care conditions subject to risk adjustment;  
1609 (ii) establishes an adjustment amount for each identified health care condition;  
1610 (iii) determines the extent to which an insurer has more or less individuals with an  
1611 identified health condition than would be expected; and  
1612 (iv) computes all risk adjustments.  
1613 (e) The board may amend the plan if necessary to:  
1614 (i) maintain the solvency of the defined contribution market;  
1615 (ii) mitigate significant issues of risk selection; or  
1616 (iii) improve the administration of the risk adjuster mechanism.  
1617 Section 29. Section **31A-42-203** is enacted to read:  
1618 **31A-42-203. Powers and duties of board.**  
1619 (1) The board shall have the power to:  
1620 (a) enter into contracts to carry out the provisions and purposes of this chapter,  
1621 including, with the approval of the commissioner, contracts with persons or other organizations  
1622 for the performance of administrative functions;  
1623 (b) sue or be sued, including taking legal action necessary to implement and enforce  
1624 the plan for risk adjustment adopted pursuant to this chapter; and  
1625 (c) establish appropriate rate adjustments, underwriting policies, and other actuarial  
1626 functions appropriate to the operation of the defined contribution arrangement market in  
1627 accordance with Section 31A-42-202.  
1628 (2) (a) The board shall prepare and submit an annual report to the department for  
1629 inclusion in the department's annual market report, which shall include:  
1630 (i) the expenses of administration of the risk adjuster for the defined contribution  
1631 arrangement market;  
1632 (ii) a description of the types of policies sold in the defined contribution arrangement  
1633 market;  
1634 (iii) the number of insured lives in the defined contribution arrangement market; and  
1635 (iv) the number of insured lives in health benefit plans that do not include state  
1636 mandates.  
1637 (b) The budget for operation of the risk adjuster is subject to the approval of the board.  
1638 (c) The administrative budget of the board and the commissioner under this chapter

1639 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is  
1640 subject to review and approval by the Legislature.

1641 (3) The board shall report to the Health Reform Task Force and to the Legislative  
1642 Management Committee prior to October 1, 2009 and again prior to October 1, 2010 regarding:

1643 (a) the board's progress in developing the plan required by this chapter; and

1644 (b) the board's progress in:

1645 (i) expanding choice of plans in the defined contribution market; and

1646 (ii) expanding access to the defined contribution market in the Internet portal for large  
1647 employer groups.

1648 Section 30. Section **31A-42-204** is enacted to read:

1649 **31A-42-204. Powers of commissioner.**

1650 (1) The commissioner shall, after notice and hearing, approve the plan of operation if  
1651 the commissioner determines that the plan:

1652 (a) is consistent with this chapter; and

1653 (b) is a fair and reasonable administration of the risk adjuster.

1654 (2) The plan shall be effective upon the adoption of administrative rules by the  
1655 commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

1656 (3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any  
1657 time thereafter fails to submit proposed amendments to the plan of operation within a  
1658 reasonable time after requested by the commissioner, the commissioner shall, after notice and  
1659 hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

1660 (4) Rules promulgated by the commissioner shall continue in force until modified by  
1661 the commissioner or until superseded by a subsequent plan of operation submitted by the board  
1662 and approved by the commissioner.

1663 (5) The commissioner may designate an executive secretary from the department to  
1664 provide administrative assistance to the board in carrying out its responsibilities.

1665 Section 31. Section **63M-1-2504** is amended to read:

1666 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**

1667 (1) There is created within the Governor's Office of Economic Development the Office  
1668 of Consumer Health Services.

1669 (2) The office shall:

1670 (a) in cooperation with the Insurance Department, the Department of Health, and the  
1671 Department of Workforce Services, and in accordance with the electronic standards developed  
1672 under ~~[Section]~~ Sections 31A-22-635 and 63M-1-2506, create an Internet portal that:

1673 (i) is capable of providing access to private and government health insurance websites  
1674 and their electronic application forms and submission procedures;

1675 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted  
1676 on the Internet portal by an insurer for the:

1677 (A) small employer group market;

1678 (B) the individual market; and

1679 (C) the defined contribution arrangement market; and

1680 (iii) includes information and a link to enrollment in premium assistance programs and  
1681 other government assistance programs;

1682 (b) facilitate a private sector method for the collection of health insurance premium  
1683 payments made for a single policy by multiple payers, including the policyholder, one or more  
1684 employers of one or more individuals covered by the policy, government programs, and others  
1685 by educating employers and insurers about collection services available through private  
1686 vendors, including financial institutions; ~~[and]~~

1687 (c) assist employers with a free or low cost method for establishing mechanisms for the  
1688 purchase of health insurance by employees using pre-tax dollars[-];

1689 (d) periodically convene health care providers, payers, and consumers to monitor the  
1690 progress being made regarding demonstration projects for health care delivery and payment  
1691 reform; and

1692 (e) report to the Business and Labor Interim Committee and the Health Reform Task  
1693 Force prior to November 1, 2009 and November 1, 2010 regarding:

1694 (i) the operations of the Internet portal required by this chapter; and

1695 (ii) the progress of the demonstration projects for health care payment and delivery  
1696 reform.

1697 (3) The office:

1698 (a) may not:

1699 ~~[(a)]~~ (i) regulate health insurers, health insurance plans, or health insurance producers;

1700 ~~[(b)]~~ (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

1701 ~~(e)~~ (iii) act as an appeals entity for resolving disputes between a health insurer and an  
1702 insured[-]; and

1703 (b) may establish and collect a fee in accordance with Section 63J-1-303 for the  
1704 transaction cost of:

1705 (i) processing an application for a health benefit plan from the Internet portal to an  
1706 insurer; and

1707 (ii) accepting, processing, and submitting multiple premium payment sources.

1708 Section 32. Section **63M-1-2506** is enacted to read:

1709 **63M-1-2506. Health benefit plan information on Internet portal -- Insurer**  
1710 **transparency.**

1711 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,  
1712 Chapter 3, Utah Administrative Rulemaking Act, that:

1713 (i) establish uniform electronic standards for:

1714 (A) a health insurer to use when:

1715 (I) transmitting information to the Internet portal; or

1716 (II) receiving information from the Internet portal; and

1717 (B) facilitating the transmission and receipt of premium payments from multiple  
1718 sources in the defined contribution arrangement market;

1719 (ii) designate the level of detail that would be helpful for a concise consumer  
1720 comparison of the items described in Subsections (4)(a) through (d) on the Internet portal; and

1721 (iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined  
1722 Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on  
1723 the Internet portal with the determination of when an employer is eligible to participate in the  
1724 Internet portal defined contribution market under Title 31A, Chapter 30, Part 2, Defined  
1725 Contribution Arrangements.

1726 (b) The office shall post or facilitate the posting of:

1727 (i) the information required by this section on the Internet portal created by this part;  
1728 and

1729 (ii) links to websites that provide cost and quality information from the Department of  
1730 Health Data Committee or neutral entities with a broad base of support from the provider and  
1731 payer communities.



1732 (2) A health insurer shall use the uniform electronic standards when transmitting  
1733 information to the Internet portal or receiving information from the Internet portal.

1734 (3) (a) An insurer who participates in the defined contribution arrangement market  
1735 under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans  
1736 offered in that market on the Internet portal and shall comply with the provisions of this  
1737 section.

1738 (b) An insurer who offers products under Title 31A, Chapter 30, Part 1, Individual and  
1739 Small Employer Group:

1740 (i) shall post the basic benefit plan required by Section 31A-22-613.5 for individual  
1741 and small employer group plans on the Internet portal if the insurer's plans are offered to the  
1742 general public;

1743 (ii) may publish any other health benefit plans that it offers on the Internet portal; and

1744 (iii) shall comply with the provisions of this section for every health benefit plan it  
1745 posts on the Internet portal.

1746 (4) A health insurer shall provide the Internet portal with the following information for  
1747 each health benefit plan submitted to the Internet portal:

1748 (a) plan design, benefits, and options offered by the health benefit plan including state  
1749 mandates the plan does not cover;

1750 (b) provider networks;

1751 (c) wellness programs and incentives;

1752 (d) descriptions of prescription drug benefits, exclusions, or limitations; and

1753 (e) at the same time as information is submitted under Subsection 31A-30-208(2), the  
1754 following operational measures for each health insurer that submits information to the Internet  
1755 portal:

1756 (i) the percentage of claims paid by the insurer within 30 days of the date a claim is  
1757 submitted to the insurer for the prior year; and

1758 (ii) the number of adverse benefit determinations by the insurer which were  
1759 subsequently overturned on independent review under Section 31A-22-629 as a percentage of  
1760 total claims paid by the insurer for the prior year.

1761 (5) The Insurance Department shall post on the Internet portal the Insurance  
1762 Department's solvency rating for each insurer who posts a health benefit plan on the Internet

1763 portal. The solvency rating for each carrier shall be based on methodology established by the  
1764 Insurance Department by administrative rule and shall be updated each calendar year.

1765 (6) The commissioner may request information from an insurer under Section  
1766 31A-22-613.5 to verify the data submitted to the Internet portal under this section.

1767 (7) A health insurer shall accept and process an application for a health benefit plan  
1768 from the Internet portal in accordance with Section 31A-22-635.

1769 **Section 33. Health Reform Task Force -- Creation -- Membership -- Interim rules**  
1770 **followed -- Compensation -- Staff.**

1771 (1) There is created the Health Reform Task Force consisting of the following 11  
1772 members:

1773 (a) four members of the Senate appointed by the president of the Senate, no more than  
1774 three of whom may be from the same political party; and

1775 (b) seven members of the House of Representatives appointed by the speaker of the  
1776 House of Representatives, no more than five of whom may be from the same political party.

1777 (2) (a) The president of the Senate shall designate a member of the Senate appointed  
1778 under Subsection (1)(a) as a co-chair of the committee.

1779 (b) The speaker of the House of Representatives shall designate a member of the House  
1780 of Representatives appointed under Subsection (1)(b) as a co-chair of the committee.

1781 (3) In conducting its business, the committee shall comply with the rules of legislative  
1782 interim committees.

1783 (4) Salaries and expenses of the members of the committee shall be paid in accordance  
1784 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage  
1785 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override  
1786 Sessions.

1787 (5) The Office of Legislative Research and General Counsel shall provide staff support  
1788 to the committee.

1789 **Section 34. Duties -- Interim report.**

1790 (1) The committee shall review and make recommendations on the following issues:

1791 (a) the state's progress in implementing the strategic plan for health system reform as  
1792 described in Section 63M-1-2505;

1793 (b) the implementation of statewide demonstration projects to provide systemwide

1794 aligned incentives for the appropriate delivery of and payment for health care;  
1795 (c) the development of the defined contribution arrangement market and the plan  
1796 developed by the risk adjuster board for implementation by January 1, 2012, including:  
1797 (i) increased selection of health benefit plans in the defined contribution market;  
1798 (ii) participation by large employer groups in the defined contribution market; and  
1799 (iii) risk allocation in the defined contribution market;  
1800 (d) the operations and progress of the Internet portal;  
1801 (e) mechanisms to increase transparency in the market, including:  
1802 (i) developing measurements and methodology for insurers to provide medical loss  
1803 ratios as a percentage of premiums; and  
1804 (ii) administrative overhead as a percentage of total revenue;  
1805 (f) the implementation and effectiveness of insurer wellness programs and incentives,  
1806 including outcome measures for the programs; and  
1807 (g) clarification from the U.S. Department of Labor regarding whether the federal  
1808 Health Insurance Portability and Accountability Act, federal ERISA laws, and the Internal  
1809 Revenue Code will permit an employer to offer pre-tax income to an individual for the  
1810 purchase of a health benefit policy in the defined contribution market and allow the individual  
1811 to purchase a health benefit policy that:  
1812 (i) is owned by the individual, separate from the employer group plan; and  
1813 (ii) is not subject to the employment relationship with the employer and is therefore  
1814 fully portable.  
1815 (h) development of strategies for promoting health and wellness and highlighting the  
1816 health risks associated with such things as obesity and sedentary lifestyles;  
1817 (i) providing greater transparency for consumers by:  
1818 (A) increasing the ability of individuals to obtain pre-service estimates from health care  
1819 providers;  
1820 (B) determining, with providers, payers and consumers how to make the insurance  
1821 explanation of benefits more understandable;  
1822 (C) determining if the terminology used by insurers regarding copayments, deductibles  
1823 and cost sharing can be standardized or made more understandable to consumers and providers;  
1824 and

1825 (D) developing with providers and insurers a more efficient process for  
1826 pre-authorization from an insurer for a medical procedure;

1827 (j) the nature and significance of cost shifting between public programs and private  
1828 insurance, and exploring strategies for reducing the level of the cost shift;

1829 (k) the role that the Public Employees Health Program and other associations that  
1830 provide insurance may play in the defined contribution market portal;

1831 (l) the development of strategies to keep community leaders, business leaders and the  
1832 public involved in the process of health care reform;

1833 (m) the development of a process to help the public understand the circumstances  
1834 underlying significant cost increase within the healthcare market or regional treatment  
1835 variances; and

1836 (n) the consideration of insurance reimbursement disincentives for a healthcare  
1837 provider to choose the most effective and efficient treatment method for a patient.

1838 (2) A final report, including any proposed legislation shall be presented to the Business  
1839 and Labor Interim Committee before November 30, 2009.

1840 **Section 35. Effective date.**

1841 If approved by two-thirds of all the members elected to each house, this bill takes effect  
1842 upon approval by the governor, or the day following the constitutional time limit of Utah  
1843 Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto,  
1844 the date of veto override.

1845 **Section 36. Repeal date.**

1846 The Health System Reform Task Force created in Sections 33 and 34 of this bill is  
1847 repealed December 30, 2009.

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**H.B. 188 2nd Sub. (Gray) - Health System Reform - Insurance Market**

**Fiscal Note**

2009 General Session  
State of Utah

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**State Impact**

Enactment of this bill will require an ongoing appropriation from dedicated credits of \$70,000 per year beginning in FY 2010. An additional \$100,000 in one-time dedicated credits may be required in FY 2012 for actuarial services.

|                   | <u>2009</u><br><u>Approp.</u> | <u>2010</u><br><u>Approp.</u> | <u>2011</u><br><u>Approp.</u> | <u>2009</u><br><u>Revenue</u> | <u>2010</u><br><u>Revenue</u> | <u>2011</u><br><u>Revenue</u> |
|-------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Dedicated Credits | \$0                           | \$70,000                      | \$70,000                      | \$0                           | \$0                           | \$0                           |
| <b>Total</b>      | <b>\$0</b>                    | <b>\$70,000</b>               | <b>\$70,000</b>               | <b>\$0</b>                    | <b>\$0</b>                    | <b>\$0</b>                    |

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

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals or local governments. Certain businesses may incur costs associated with reform efforts.

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