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H.B. 144
1st Sub. (Buff)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH SYSTEM REFORM AMENDMENTS

2012 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends provisions in the Health Code and Insurance Code related to the state's strategic plan for health system reform.

Highlighted Provisions:

This bill:

- clarifies the role of the All Payer Claims Database and the Utah Health Exchange related to prospective and retrospective risk adjusting;
- makes technical amendments to the Health Department's reports that compare quality measures;
- amends provisions related to simplified Medicaid enrollment;
- authorizes an actuarial analysis of providing coverage options to individuals from 133% to 200% of the federal poverty level through a basic health plan beginning in 2014;
- amends provisions related to the benchmark plan for the dental program in the Children's Health Insurance Program;
- allows dental and vision policies on the health insurance exchange if the insurance department adopts rules in consultation with the Health Reform Task Force which permit vision and dental plans on the exchange;

- amends health insurance producer disclosure requirements;
- allows an insurer to provide a premium discount to an employer group based on participation in a wellness program;
- establishes the Legislature as the entity to determine the benchmark for an essential health benefit plan for the state;
- clarifies the fees that may be charged for the use of the call center for the Utah Health Exchange;
- re-authorizes the Health System Reform Task Force;
- repeals provisions that require the state to implement multipayer demonstration projects; and
- makes technical amendments.

Money Appropriated in this Bill:

This bill appropriates in fiscal year 2011-12:

- To the Senate, as a one-time appropriation:
  - from the General Fund $15,000 to pay for the Health System Reform Task Force; and
- To the House of Representatives, as a one-time appropriation:
  - from the General Fund $25,000 to pay for the Health System Reform Task Force.

Other Special Clauses:

This bill provides a repeal date.

Utah Code Sections Affected:

AMENDS:

26-18-2.5, as enacted by Laws of Utah 2011, Chapter 344

26-33a-106.1, as last amended by Laws of Utah 2010, Chapter 68

26-33a-106.5, as last amended by Laws of Utah 2011, Chapters 297 and 400

26-40-106, as last amended by Laws of Utah 2011, Chapter 400

31A-30-106.1, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5

31A-22-613.5, as last amended by Laws of Utah 2011, Chapters 297 and 400

31A-22-635, as last amended by Laws of Utah 2011, Chapter 400

31A-23a-501, as last amended by Laws of Utah 2011, Chapters 284 and 297

63I-2-231, as last amended by Laws of Utah 2011, Chapter 284

63M-1-2504, as last amended by Laws of Utah 2011, Chapter 400

ENACTS:

26-18-3.8, Utah Code Annotated 1953

31A-30-116, Utah Code Annotated 1953

REPEALS:

26-1-39, as enacted by Laws of Utah 2011, Chapter 400

31A-22-614.6, as last amended by Laws of Utah 2011, Chapter 400

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

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

Section 1. Section **26-18-2.5** is amended to read:

26-18-2.5. Simplified enrollment and renewal process for Medicaid and other state medical programs -- Financial institutions.

(1) The department [~~shall~~] may:

(a) apply for grants and accept donations to:

(i) make technology system improvements necessary to implement a simplified enrollment and renewal process for the Medicaid program, Utah Premium Partnership, and Primary Care Network Demonstration Project programs; and

(ii) conduct an actuarial analysis of the implementation of a basic health care plan in the state in 2014 to provide coverage options to individuals from 133% to 200% of the federal poverty level; and

(b) if funding is available[~~,~~]:

(i) implement the simplified enrollment and renewal process in accordance with this section[~~.~~]; and

(ii) conduct the actuarial analysis described in Subsection (1)(a)(ii).

(2) The simplified enrollment and renewal process established in this section shall, in accordance with Section 59-1-403, provide an eligibility worker a process in which the eligibility worker:

(a) verifies the applicant's or enrollee's identity;

(b) gets consent to obtain the applicant's adjusted gross income from the State Tax Commission from:

(i) the applicant or enrollee, if the applicant or enrollee filed a single tax return; or

(ii) both parties to a joint return, if the applicant filed a joint tax return; and

(c) obtains from the State Tax Commission, the adjusted gross income of the applicant or enrollee.

(3) (a) The department may enter into an agreement with a financial institution doing business in the state to develop and operate a data match system to identify an applicant's or enrollee's assets that:

(i) uses automated data exchanges to the maximum extent feasible; and

(ii) requires a financial institution each month to provide the name, record address, Social Security number, other taxpayer identification number, or other identifying information for each applicant or enrollee who maintains an account at the financial institution.

(b) The department may pay a reasonable fee to a financial institution for compliance with this Subsection (3), as provided in Section 7-1-1006.

(c) A financial institution may not be liable under any federal or state law to any person for any disclosure of information or action taken in good faith under this Subsection (3).

(d) The department may disclose a financial record obtained from a financial institution under this section only for the purpose of, and to the extent necessary in, verifying eligibility as provided in this section and Section 26-40-105.

[~~(4) The simplified enrollment and renewal process established under this section shall be implemented by the department no later than July 1, 2012.~~]

Section 2. Section **26-18-3.8** is enacted to read:

26-18-3.8. Utah's Premium Partnership For Health Insurance -- Medicaid waiver.

The department shall seek federal approval of an amendment to the state's Utah Premium Partnership for Health Insurance program to adjust the eligibility determination for single adults and parents who have an offer of employer sponsored insurance. The amendment shall:

(1) be within existing appropriations for the Utah Premium Partnership for Health Insurance program; and

(2) provide that adults who are up to 200% of the federal poverty level are eligible for premium subsidies in the Utah Premium Partnership for Health Insurance program.

Section 3. Section **26-33a-106.1** is amended to read:

26-33a-106.1. Health care cost and reimbursement data.

(1) (a) The committee shall, as funding is available, establish an advisory panel to advise the committee on the development of a plan for the collection and use of health care data pursuant to Subsection 26-33a-104(6) and this section.

(b) The advisory panel shall include:

(i) the chairman of the Utah Hospital Association;

(ii) a representative of a rural hospital as designated by the Utah Hospital Association;

(iii) a representative of the Utah Medical Association;

(iv) a physician from a small group practice as designated by the Utah Medical Association;

(v) two representatives who are health insurers, appointed by the committee;

(vi) a representative from the Department of Health as designated by the executive director of the department;

(vii) a representative from the committee;

(viii) a consumer advocate appointed by the committee;

(ix) a member of the House of Representatives appointed by the speaker of the House; and

(x) a member of the Senate appointed by the president of the Senate.

(c) The advisory panel shall elect a chair from among its members, and shall be staffed by the committee.

(2) (a) The committee shall, as funding is available:

(i) establish a plan for collecting data from data suppliers, as defined in Section 26-33a-102, to determine measurements of cost and reimbursements for risk adjusted episodes of health care;

[~~(ii) assist the demonstration projects implemented by the Insurance Department pursuant to Section 31A-22-614.6, with access to cost data, reimbursement data, care process data, and provider service data necessary for the demonstration projects' research, statistical analysis, and quality improvement activities:~~]

[~~(A) notwithstanding Subsection 26-33a-108(1) and Section 26-33a-109;~~]

[~~(B) contingent upon approval by the committee; and~~]

[~~(C) subject to a contract between the department and the entity providing analysis for the demonstration project;~~]

[~~(iii)~~] (ii) share data regarding insurance claims and an individual's and small employer group's health risk factor with insurers participating in the defined contribution market created in Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, only to the extent necessary for:

(A) [~~renewals of policies~~] establishing rates and prospective risk adjusting in the defined contribution arrangement market; and

(B) risk adjusting in the defined contribution arrangement market; and

[~~(iv)~~] (iii) assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting on:

(A) geographic variances in medical care and costs as demonstrated by data available to the committee; and

(B) rate and price increases by health care providers:

(I) that exceed the Consumer Price Index - Medical as provided by the United States Bureau of Labor statistics;

(II) as calculated yearly from June to June; and

(III) as demonstrated by data available to the committee.

(b) The plan adopted under this Subsection (2) shall include:

(i) the type of data that will be collected;

(ii) how the data will be evaluated;

(iii) how the data will be used;

(iv) the extent to which, and how the data will be protected; and

(v) who will have access to the data.

Section 4. Section **26-33a-106.5** is amended to read:

26-33a-106.5. Comparative analyses.

(1) The committee may publish compilations or reports that compare and identify health care providers or data suppliers from the data it collects under this chapter or from any other source.

(2) (a) The committee shall publish compilations or reports from the data it collects under this chapter or from any other source which:

(i) contain the information described in Subsection (2)(b); and

(ii) compare and identify by name at least a majority of the health care facilities and institutions in the state.

(b) The report required by this Subsection (2) shall:

(i) be published at least annually; and

(ii) contain comparisons based on at least the following factors:

(A) nationally or other generally recognized quality standards;

(B) charges; and

(C) nationally recognized patient safety standards.

(3) The committee may contract with a private, independent analyst to evaluate the standard comparative reports of the committee that identify, compare, or rank the performance of data suppliers by name. The evaluation shall include a validation of statistical methodologies, limitations, appropriateness of use, and comparisons using standard health services research practice. The analyst shall be experienced in analyzing large databases from multiple data suppliers and in evaluating health care issues of cost, quality, and access. The results of the analyst's evaluation shall be released to the public before the standard comparative analysis upon which it is based may be published by the committee.

(4) The committee shall adopt by rule a timetable for the collection and analysis of data from multiple types of data suppliers.

(5) The comparative analysis required under Subsection (2) shall be available:

(a) free of charge and easily accessible to the public; and

(b) on the Health Insurance Exchange either directly or through a link.

(6) (a) [~~On or before December 1, 2011, the~~] The department shall include in the report required by Subsection (2)(b), or include in a separate report, comparative information on commonly recognized or generally agreed upon measures of quality identified in accordance with Subsection (7), for:

(i) routine and preventive care; and

(ii) the treatment of diabetes, heart disease, and other illnesses or conditions.

(b) The comparative information required by Subsection (6)(a) shall be based on data

collected under Subsection (2) and clinical data that may be available to the committee, and shall [~~be reported as a statewide aggregate for facilities and clinics.~~] beginning on or after July 1, 2012, compare:

[~~(c) The department shall, in accordance with Subsection (7)(c), publish reports on or after July 1, 2012, based on the quality measures described in Subsection (6)(a), using the data collected under Subsection (2) and clinical data that may be available to the committee, that compare:~~]

(i) results for health care facilities or institutions;

(ii) a clinic's aggregate results for a physician who practices at a clinic with five or more physicians; and

(iii) a geographic region's aggregate results for a physician who practices at a clinic with less than five physicians, unless the physician requests physician-level data to be published on a clinic level.

[~~(d)~~] (c) The department:

(i) may publish information required by this Subsection (6) directly or through one or more nonprofit, community-based health data organizations;

(ii) may use a private, independent analyst under Subsection (3) in preparing the report required by this section; and

(iii) shall identify and report to the Legislature's Health and Human Services Interim Committee by July 1, 2012, and every July 1, thereafter until July 1, 2015, at least five new measures of quality to be added to the report each year.

[~~(e)~~] (d) A report published by the department under this Subsection (6):

(i) is subject to the requirements of Section 26-33a-107; and

(ii) shall, prior to being published by the department, be submitted to a neutral, non-biased entity with a broad base of support from health care payers and health care providers in accordance with Subsection (7) for the purpose of validating the report.

(7) (a) The Health Data Committee shall, through the department, for purposes of Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral, non-biased entity with a broad base of support from health care payers and health care providers.

(b) If the entity described in Subsection (7)(a) does not submit the quality measures

[~~prior to July 1, 2011~~], the department may select the appropriate number of quality measures for purposes of the report required by Subsection (6).

(c) (i) For purposes of the reports published on or after July 1, 2012, the department may not compare individual facilities or clinics as described in Subsections (6)[~~(c)~~](b)(i) through (iii) if the department determines that the data available to the department can not be appropriately validated, does not represent nationally recognized measures, does not reflect the mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing providers.

(ii) The department shall report to the Legislature's Executive Appropriations Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).

[~~(d) The committee and the department shall report to the Legislature's Health System Reform Task Force on or before November 1, 2011, regarding the department's progress in creating a system to validate the data and address the issues described in Subsection(7)(c).~~]

Section 5. Section **26-40-106** is amended to read:

26-40-106. Program benefits.

(1) Until the department implements a plan under Subsection (2), program benefits may include:

(a) hospital services;

(b) physician services;

(c) laboratory services;

(d) prescription drugs;

(e) mental health services;

(f) basic dental services;

(g) preventive care including:

(i) routine physical examinations;

(ii) immunizations;

(iii) basic vision services; and

(iv) basic hearing services;

(h) limited home health and durable medical equipment services; and

(i) hospice care.

(2) (a) Except as provided in Subsection (2)(d), no later than July 1, 2008, the medical

program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, to be actuarially equivalent to a health benefit plan with the largest insured commercial enrollment offered by a health maintenance organization in the state.

(b) Except as provided in Subsection (2)(d), after July 1, [~~2008~~] 2012:

(i) medical program benefits may not exceed the benefit level described in Subsection (2)(a); and

(ii) medical program benefits shall be adjusted every July 1, thereafter to meet the benefit level described in Subsection (2)(a).

(c) The dental benefit plan shall be benchmarked, in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the state, except that the utilization review mechanism for orthodontia shall be based on medical necessity. Dental program benefits shall be adjusted on July 1, 2012, and on July 1 every three years thereafter to meet the benefit level required by this Subsection (2)(c).

(d) The program benefits for enrollees who are at or below 100% of the federal poverty level are exempt from the benchmark requirements of Subsections (2)(a) and (2)(b).

Section 6. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance.

(1) (a) This section applies to all health benefit plans.

(b) Subsection (2) applies to:

(i) all health benefit plans; and

(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) (a) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to:

(i) provide to all enrollees, prior to enrollment in the health benefit plan written disclosure of:

(A) restrictions or limitations on prescription drugs and biologics including:

(I) the use of a formulary;

(II) co-payments and deductibles for prescription drugs; and

(III) requirements for generic substitution;

(B) coverage limits under the plan; and

(C) any limitation or exclusion of coverage including:

(I) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

(II) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition; and

(ii) provide the commissioner with:

(A) the information described in Subsections 31A-22-635(5) through (7) in the standardized electronic format required by Subsection 63M-1-2506(1); and

(B) information regarding insurer transparency in accordance with Subsection (4).

(b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to the commissioner:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):

(A) treatment policies;

(B) practice standards;

(C) restrictions;

(D) coverage limits of the insurer's health benefit plan or health insurance policy; or

(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

(c) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

(d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

(e) (i) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(3) The commissioner:

(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Section 63M-1-2504; and

(b) may request information from an insurer to verify the information submitted by the insurer under this section.

(4) The commissioner shall:

(a) convene a group of insurers, a member representing the Public Employees' Benefit and Insurance Program, consumers, and an organization [~~described in Subsection 31A-22-614.6(3)(b)~~] that provides multipayer and multiprovider quality assurance and data collection, to develop information for consumers to compare health insurers and health benefit plans on the Health Insurance Exchange, which shall include consideration of:

(i) the number and cost of an insurer's denied health claims;

(ii) the cost of denied claims that is transferred to providers;

(iii) the average out-of-pocket expenses incurred by participants in each health benefit plan that is offered by an insurer in the Health Insurance Exchange;

(iv) the relative efficiency and quality of claims administration and other administrative processes for each insurer offering plans in the Health Insurance Exchange; and

(v) consumer assessment of each insurer or health benefit plan;

(b) adopt an administrative rule that establishes:

(i) definition of terms;

(ii) the methodology for determining and comparing the insurer transparency information;

(iii) the data, and format of the data, that an insurer shall submit to the commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(iv) the dates on which the insurer shall submit the data to the commissioner in order for the commissioner to transmit the data to the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(c) implement the rules adopted under Subsection (4)(b) in a manner that protects the business confidentiality of the insurer.

Section 7. Section **31A-22-635** is amended to read:

31A-22-635. Uniform application -- Uniform waiver of coverage -- Information on Health Insurance Exchange.

(1) For purposes of this section, "insurer":

(a) is defined in Subsection 31A-22-634(1); and

(b) includes the state employee's risk pool under Section 49-20-202.

(2) (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.

(b) The uniform application form:

(i) except for cancer and transplants, may not include questions about an applicant's health history prior to the previous five years; and

(ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.

(c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions other than pregnancy, and is limited to:

(i) information that identifies the employee;

(ii) proof of the employee's insurance coverage; and

(iii) a statement that the employee declines coverage with a particular employer group.

(3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may be combined or modified to facilitate a more efficient and consumer friendly experience for enrollees using the Health Insurance Exchange if the modification is approved by the commissioner.

(4) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(5) (a) An insurer who offers a health benefit plan in either the group or individual market on the Health Insurance Exchange created in Section 63M-1-2504, shall:

(i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to Section 63M-1-2506;

(ii) if requested, provide the applicant with a copy of the completed application either by mail or electronically;

(iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and

(iv) post the information required by Subsection (6) on the Health Insurance Exchange for every health benefit plan the insurer offers on the Health Insurance Exchange.

(b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans on the Health Insurance Exchange may not directly or indirectly offer products on the Health Insurance Exchange that are not health benefit plans.

(c) Notwithstanding Subsection (5)(b)[~~,~~]:

(i) an insurer may offer a health savings account on the Health Insurance Exchange[~~,~~]; and

(ii) an insurer may offer dental and vision plans on the Health Insurance Exchange if:

(A) the department determines, after study and consultation with the Health System Reform Task Force, that the department is able to establish standards for dental and vision policies offered on the health insurance exchange, and the department determines whether a risk adjuster mechanism is necessary for a defined contribution vision and dental plan market on the Health Insurance Exchange; and

(B) the department, in accordance with recommendations from the Health System Reform Task Force, adopts administrative rules to regulate the offer of dental and vision plans on the Health Insurance Exchange.

(6) An insurer shall provide the commissioner and the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance

Exchange, in the electronic format required by Subsection 63M-1-2506(1):

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

(b) information and Internet address to online provider networks;

(c) wellness programs and incentives;

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

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

(f) the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(4).

(7) The Insurance Department shall post on the Health Insurance Exchange the Insurance Department's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each insurer shall be based on methodology established by the Insurance Department by administrative rule and shall be updated each calendar year.

(8) (a) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health Insurance Exchange.

(b) The commissioner shall regulate any fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Section 8. Section **31A-23a-501** is amended to read:

31A-23a-501. Licensee compensation.

(1) As used in this section:

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

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

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

(b) (i) "Compensation from an insurer or third party administrator" means commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,

gifts, prizes, or any other form of valuable consideration:

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

(B) received from:

(I) an insurer; or

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

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

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

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

(c) (i) "Customer" means:

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

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

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

(A) an employee benefit plan; or

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

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

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

(e) "Pass-through costs" include:

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

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

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

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

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

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

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

(b) Noncommission compensation shall be:

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

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

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

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

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

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

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

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

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

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

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

(c) The following additional noncommission compensation is authorized:

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

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a

claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

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

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

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

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) [~~Beginning January 1, 2010, in addition to any other disclosures required by this section, a~~] A producer may not accept or receive any compensation from an insurer or third party administrator for the initial placement of a health benefit plan, other than a hospital confinement indemnity policy, unless prior to the customer's initial purchase of the health benefit plan the producer[~~: (i) except as provided in Subsection (4)(c),~~] discloses in writing to the customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer at the time of the disclosure[~~; and~~].

[~~(ii) except as provided in Subsection (4)(c):~~]

[~~(A) obtains~~] (c) A producer shall:

(i) obtain the customer's signed acknowledgment that the disclosure under Subsection (4)(b)[~~(i)~~] was made to the customer; or

[~~(B) (I) signs~~] (ii) (A) sign a statement that the disclosure required by Subsection (4)(b)[~~(i)~~] was made to the customer; and

[~~(II) keeps~~] (B) keep the signed statement on file in the producer's office while the health benefit plan placed with the customer is in force.

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

(d) (i) A licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit shall, while the health benefit plan placed with the customer is in force, maintain a copy of:

(A) the signed acknowledgment described in Subsection (4)[~~(b)(i)~~](c)(i); or

(B) the signed statement described in Subsection (4)[~~(b)(ii)~~](c)(ii).

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

(e) Subsection (4)[~~(b)(ii)~~](c) does not apply to:

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

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

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

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

(7) A licensee may not receive noncommission compensation from an insured or enrollee for providing a service or engaging in an act that is required to be provided or performed in order to receive commission compensation, except for the surplus lines transactions that do not receive commissions.

Section 9. Section **31A-30-106.1** is amended to read:

31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for small employer health benefit plans under this chapter are subject to this section.

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

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to an employer group under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except when catastrophic

mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

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

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

(b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the small employer carrier's rate manual for the class of business, except when catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d); and

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

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

(b) Rating adjustments and factors, including case characteristics, shall be applied uniformly and consistently to the rates charged for all employees and dependents of the small employer.

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

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

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

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

(5) A health benefit plan that uses a restricted network provision may not be considered similar coverage to a health benefit plan that does not use a restricted network provision, provided that use of the restricted network provision results in substantial difference in claims costs.

(6) The small employer carrier may not use case characteristics other than the following:

(a) age of the employee, in accordance with Subsection (7);

(b) geographic area;

(c) family composition in accordance with Subsection (9);

(d) for plans renewed or effective on or after July 1, 2011, gender of the employee and spouse; [~~and~~]

(e) for an individual age 65 and older, whether the employer policy is primary or secondary to Medicare[~~.~~]; and

(f) for small employer group coverage, group participation in a wellness program, limited to a discount that does not exceed 20% of the premium for the small employer group.

(7) Age limited to:

(a) the following age bands:

(i) less than 20;

(ii) 20-24;

(iii) 25-29;

(iv) 30-34;

(v) 35-39;

(vi) 40-44;

(vii) 45-49;

(viii) 50-54;

(ix) 55-59;

(x) 60-64; and

(xi) 65 and above; and

(b) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (9)(b):

(i) as developed by the commissioner by administrative rule; and

(ii) not to exceed an overall ratio as provided in Subsection (8).

(8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:

(i) 5:1 for plans renewed or effective before January 1, 2012; and

(ii) 6:1 for plans renewed or effective on or after January 1, 2012; and

(b) the age slope ratios for each age band may not overlap.

(9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:

(a) an overall ratio of:

(i) 5:1 or less for plans renewed or effective before January 1, 2012; and

(ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and

(b) a tier rating structure that includes:

(i) four tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a child or children; and

(D) a family, consisting of an employee plus spouse, and a child or children;

(ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children; and

(E) employee plus spouse plus one or more children; or

(iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children;

(E) employee plus spouse plus one child; and

(F) employee plus spouse plus two or more children.

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

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

(b) A covered carrier may not offer to transfer a covered insured into or out of a class

of business unless the offer is made to transfer all covered insureds in the class of business without regard to:

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

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

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

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

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

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

(ii) A copy of the certification required by Subsection (12)(b)(i) shall be retained by the small employer carrier at the small employer carrier's principal place of business.

(c) A small employer carrier shall make the information and documentation described in this Subsection (12) available to the commissioner upon request.

(13) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) implement this chapter; and

(ii) assure that rating practices used by small employer carriers under this section and carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this chapter.

(b) The rules may:

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

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

(14) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Section 10. Section **31A-30-116** is enacted to read:

31A-30-116. Essential health benefits.

(1) For purposes of this section, the "Affordable Care Act" is as defined in Section 31A-2-212 and includes federal rules related to the offering of essential health benefits.

(2) The state chooses to designate its own essential health benefits rather than accept a federal determination of the essential health benefits required to be offered in the individual and small group market for plans renewed or offered on or after January 1, 2014.

(3) (a) Subject to Subsections (3)(b) and (c), to the extent required by the Affordable Care Act, and after considering public testimony, the Legislature's Health System Reform Task Force shall recommend to the commissioner, no later than September 1, 2012, a benchmark plan for the state's essential health benefits based on:

(i) the largest plan by enrollment in any of the three largest small employer group insurance products in the state's small employer group market;

(ii) any of the largest three state employee health benefit plans by enrollment;

(iii) the largest insured commercial non-Medicaid health maintenance organization operating in the state; or

(iv) other benchmarks required or permitted by the Affordable Care Act.

(b) Notwithstanding the provisions of Subsection 63M-1-2505.5(2), based on the recommendation of the task force under Subsection (3)(a), and within 30 days of the task force recommendation, the commissioner shall adopt an emergency administrative rule that designates the essential health benefits that shall be included in a plan offered or renewed on or after January 1, 2014, in the small employer group and individual markets.

(c) The essential health benefit plan:

(i) shall not include a state mandate if the inclusion of the state mandate would require the state to contribute to premium subsidies under the Affordable Care Act; and

(ii) may add benefits in addition to the benefits included in a benchmark plan described

in Subsection (3)(b) if the additional benefits are mandated under the Affordable Care Act.

Section 11. Section **63I-2-231** is amended to read:

63I-2-231. Repeal dates, Title 31A.

Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed [~~January 1, 2013~~] July 1, 2013.

Section 12. Section **63M-1-2504** is amended to read:

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

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

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:

(i) provides information to consumers about private and public health programs for which the consumer may qualify;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange; and

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

(b) contract with one or more private vendors for:

(i) administration of the enrollment process on the Health Insurance Exchange, including establishing a mechanism for consumers to compare health benefit plan features on the exchange and filter the plans based on consumer preferences;

(ii) the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others; and

(iii) establishing a call center in accordance with Subsection (3);

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

(d) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the Health Insurance

Exchange; and

(e) report to the Business and Labor Interim Committee and the Health System Reform Task Force [~~prior to November 1, 2011, and~~] prior to the Legislative interim day in November of each year [~~thereafter~~] regarding the operations of the Health Insurance Exchange required by this chapter.

(3) A call center established by the office:

(a) shall provide unbiased answers to questions concerning exchange operations, and plan information, to the extent the plan information is posted on the exchange by the insurer; and

(b) may not:

(i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

(ii) [~~beginning July 1, 2011,~~] receive producer compensation through the Health Insurance Exchange; and

(iii) [~~beginning July 1, 2011,~~] be designated as the default producer for an employer group that enters the Health Insurance Exchange without a producer.

(4) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, health insurance producers, or health insurance premiums charged in the exchange;

(ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

(iii) act as an appeals entity for resolving disputes between a health insurer and an insured;

(b) may establish and collect a fee Ĥ→ [~~from the employers~~] ←Ĥ for the cost of the exchange transaction in accordance with Section 63J-1-504 for:

[~~(i) the transaction cost of:~~]

[~~(A)~~] (i) processing an application for a health benefit plan;

[~~(B)~~] (ii) accepting, processing, and submitting multiple premium payment sources; [~~and~~]

[~~(C)~~] (iii) providing a mechanism for consumers to filter and compare health benefit plans in the exchange based on consumer preferences; and

[~~(ii)~~] (iv) funding the call center [~~established in accordance with Subsection (3)~~]; and

(c) shall separately itemize [~~any fees~~] the fee established under Subsection (4)(b) as part of the cost displayed for the employer selecting coverage on the exchange.

Section 13. **Repealer.**

This bill repeals:

Section **26-1-39, Health System Reform Demonstration Projects.**

Section **31A-22-614.6, Health care delivery and payment reform demonstration projects.**

Section 14. **Health System Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

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

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

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

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a cochair of the committee.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a cochair of the committee.

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

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

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

Section 15. **Duties -- Interim report.**

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

(a) the state's response to federal health care reform;

(b) health coverage for children in the state;

(c) the role and regulation of navigators assisting individuals with the selection and purchase of health benefit plans;

(d) health insurance plans available on the Utah Health Exchange, including dental and vision plans and whether dental and vision plans can be included on the exchange in 2013;

(e) the governance structure of the Utah Health Exchange, including advisory boards for the Utah Health Exchange or any other health exchange developed in the state;

(f) no later than September 1, 2012, a recommendation to the Insurance Commissioner regarding a benchmark plan for the essential health benefit plan in the individual and small employer group market in the state;

(g) the role of the state's high risk pool as a provider of a high risk product and its role in the establishment of a transitional reinsurance program;

(h) the risk adjustment mechanism for the health exchange and methods to develop and administer a risk adjustment system that limits the administrative burden on government and health insurance plans, and creates stability in the insurance market;

(i) whether the state should consider developing and offering a basic health plan in 2014 to provide coverage options for individuals from 133% to 200% of the federal poverty level;

(j) strategies to manage Medicaid expansion in 2014, including whether the Medicaid benefit plan should be the same as, or different from, the essential health benefit plan in the private insurance market;

(k) individuals with dual health insurance coverage and the impact on the market;

(l) cost containment strategies for health care, including durable medical equipment and home health care cost containment strategies;

(m) analysis of cost effective bariatric surgery coverage; and

(n) Medicaid behavioral and mental health delivery and payment reform models, including:

(i) identifying and eliminating barriers to the delivery of effective mental, behavioral, and physical health care delivery systems;

(ii) the costs and financing of mental and behavioral health care, including current cost drivers, cost shifting, cost containment measures, and the roles of local government programs, state government programs, and federal government programs; and

(iii) innovative service delivery models that facilitate access to quality, cost effective and coordinated mental, behavioral, and physical health care.

(2) A final report, including any proposed legislation shall be presented to the Health and Human Services and Business and Labor Interim Committees before November 30, 2012.

Section 16. **Appropriation.**

Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, the following sums of money are appropriated from resources not otherwise appropriated, or reduced from amounts previously appropriated, out of the funds or accounts indicated for the fiscal year beginning July 1, 2011 and ending June 30, 2012. These are additions to any amounts previously appropriated for fiscal year 2012.

To Legislature - Senate

From General Fund, One-time $15,000

Schedule of Programs:

Administration $15,000

To Legislature - House of Representatives

From General Fund, One-time $25,000

Schedule of Programs:

Administration $25,000

Section 17. **Repeal date.**

The Health System Reform Task Force is repealed December 31, 2012.