Senator Wayne L. Niederhauser proposes the following substitute bill:

1 # HEALTH SYSTEM REFORM AMENDMENTS

2 2012 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: Wayne L. Niederhauser

6

---

7 **LONG TITLE**

8 **General Description:**

9 This bill amends provisions in the Health Code and Insurance Code related to the state's

10 strategic plan for health system reform.

11 **Highlighted Provisions:**

12 This bill:

13 ▸ clarifies the role of the All Payer Claims Database and the Utah Health Exchange

14 related to prospective and retrospective risk adjusting;

15 ▸ makes technical amendments to the Health Department's reports that compare

16 quality measures;

17 ▸ amends provisions related to simplified Medicaid enrollment;

18 ▸ authorizes an actuarial analysis of providing coverage options to individuals from

19 133% to 200% of the federal poverty level through a basic health plan beginning in

20 2014;

21 ▸ amends provisions related to the benchmark plan for the dental program in the

22 Children's Health Insurance Program;

23 ▸ prohibits an insurer from denying coverage for a covered service based on a

24 diagnosis of autism unless the claim is directly related to autism;

25 ▸ allows dental and vision policies on the health insurance exchange if the insurance

26 department adopts rules in consultation with the Health Reform Task Force which permit
27 vision and dental plans on the exchange;
28 ▸ amends health insurance producer disclosure requirements;
29 ▸ allows an insurer to provide a premium discount to an employer group or an
30 employee based on participation in a wellness program in the large and small group
31 market;
32 ▸ establishes the Legislature as the entity to determine the benchmark for an essential
33 health benefit plan for the state;
34 ▸ clarifies the fees that may be charged for the use of the call center for the Utah
35 Health Exchange;
36 ▸ re-authorizes the Health System Reform Task Force;
37 ▸ repeals provisions that require the state to implement multipayer demonstration
38 projects; and
39 ▸ makes technical amendments.
40 **Money Appropriated in this Bill:**
41 This bill appropriates in fiscal year 2011-12:
42 ▸ To the Senate, as a one-time appropriation:
43 • from the General Fund $15,000 to pay for the Health System Reform Task
44 Force; and
45 ▸ To the House of Representatives, as a one-time appropriation:
46 • from the General Fund $25,000 to pay for the Health System Reform Task
47 Force.
48 **Other Special Clauses:**
49 This bill provides a repeal date.
50 **Utah Code Sections Affected:**
51 AMENDS:
52 **26-18-2.5**, as enacted by Laws of Utah 2011, Chapter 344
53 **26-33a-106.1**, as last amended by Laws of Utah 2010, Chapter 68
54 **26-33a-106.5**, as last amended by Laws of Utah 2011, Chapters 297 and 400
55 **26-40-106**, as last amended by Laws of Utah 2011, Chapter 400
56 **31A-22-613**, as last amended by Laws of Utah 2005, Chapter 78

57 **31A-22-613.5**, as last amended by Laws of Utah 2011, Chapters 297 and 400
58 **31A-22-635**, as last amended by Laws of Utah 2011, Chapter 400
59 **31A-23a-402.5**, as enacted by Laws of Utah 2011, Chapter 62
60 **31A-23a-501**, as last amended by Laws of Utah 2011, Chapters 284 and 297
61 **31A-30-106.1**, as last amended by Laws of Utah 2011, Second Special Session, Chapter
62 5
63 **63I-2-231**, as last amended by Laws of Utah 2011, Chapter 284
64 **63M-1-2504**, as last amended by Laws of Utah 2011, Chapter 400
65 ENACTS:
66 **26-18-3.8**, Utah Code Annotated 1953
67 **31A-30-116**, Utah Code Annotated 1953
68 REPEALS:
69 **26-1-39**, as enacted by Laws of Utah 2011, Chapter 400
70 **31A-22-614.6**, as last amended by Laws of Utah 2011, Chapter 400
71 **Uncodified Material Affected:**
72 ENACTS UNCODIFIED MATERIAL
73

74 *Be it enacted by the Legislature of the state of Utah:*
75 Section 1. Section **26-18-2.5** is amended to read:
76 **26-18-2.5. Simplified enrollment and renewal process for Medicaid and other**
77 **state medical programs -- Financial institutions.**
78 (1) The department [~~shall~~] may:
79 (a) apply for grants and accept donations to:
80 (i) make technology system improvements necessary to implement a simplified
81 enrollment and renewal process for the Medicaid program, Utah Premium Partnership, and
82 Primary Care Network Demonstration Project programs; and
83 (ii) conduct an actuarial analysis of the implementation of a basic health care plan in
84 the state in 2014 to provide coverage options to individuals from 133% to 200% of the federal
85 poverty level; and
86 (b) if funding is available[~~;~~]:
87 (i) implement the simplified enrollment and renewal process in accordance with this

88 section[.]; and

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

90 (2) The simplified enrollment and renewal process established in this section shall, in

91 accordance with Section 59-1-403, provide an eligibility worker a process in which the

92 eligibility worker:

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

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

95 Commission from:

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

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

98 (c) obtains from the State Tax Commission, the adjusted gross income of the applicant

99 or enrollee.

100 (3) (a) The department may enter into an agreement with a financial institution doing

101 business in the state to develop and operate a data match system to identify an applicant's or

102 enrollee's assets that:

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

104 (ii) requires a financial institution each month to provide the name, record address,

105 Social Security number, other taxpayer identification number, or other identifying information

106 for each applicant or enrollee who maintains an account at the financial institution.

107 (b) The department may pay a reasonable fee to a financial institution for compliance

108 with this Subsection (3), as provided in Section 7-1-1006.

109 (c) A financial institution may not be liable under any federal or state law to any person

110 for any disclosure of information or action taken in good faith under this Subsection (3).

111 (d) The department may disclose a financial record obtained from a financial institution

112 under this section only for the purpose of, and to the extent necessary in, verifying eligibility as

113 provided in this section and Section 26-40-105.

114 [~~(4) The simplified enrollment and renewal process established under this section shall~~

115 ~~be implemented by the department no later than July 1, 2012.~~]

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

117 **26-18-3.8. Utah's Premium Partnership For Health Insurance -- Medicaid waiver.**

118 The department shall seek federal approval of an amendment to the state's Utah

119 Premium Partnership for Health Insurance program to adjust the eligibility determination for
120 single adults and parents who have an offer of employer sponsored insurance. The amendment
121 shall:
122 (1) be within existing appropriations for the Utah Premium Partnership for Health
123 Insurance program; and
124 (2) provide that adults who are up to 200% of the federal poverty level are eligible for
125 premium subsidies in the Utah Premium Partnership for Health Insurance program.
126 Section 3. Section **26-33a-106.1** is amended to read:
127 **26-33a-106.1. Health care cost and reimbursement data.**
128 (1) (a) The committee shall, as funding is available, establish an advisory panel to
129 advise the committee on the development of a plan for the collection and use of health care
130 data pursuant to Subsection 26-33a-104(6) and this section.
131 (b) The advisory panel shall include:
132 (i) the chairman of the Utah Hospital Association;
133 (ii) a representative of a rural hospital as designated by the Utah Hospital Association;
134 (iii) a representative of the Utah Medical Association;
135 (iv) a physician from a small group practice as designated by the Utah Medical
136 Association;
137 (v) two representatives who are health insurers, appointed by the committee;
138 (vi) a representative from the Department of Health as designated by the executive
139 director of the department;
140 (vii) a representative from the committee;
141 (viii) a consumer advocate appointed by the committee;
142 (ix) a member of the House of Representatives appointed by the speaker of the House;
143 and
144 (x) a member of the Senate appointed by the president of the Senate.
145 (c) The advisory panel shall elect a chair from among its members, and shall be staffed
146 by the committee.
147 (2) (a) The committee shall, as funding is available:
148 (i) establish a plan for collecting data from data suppliers, as defined in Section
149 26-33a-102, to determine measurements of cost and reimbursements for risk adjusted episodes

150 of health care;
151 [~~(ii) assist the demonstration projects implemented by the Insurance Department~~
152 ~~pursuant to Section 31A-22-614.6, with access to cost data, reimbursement data, care process~~
153 ~~data, and provider service data necessary for the demonstration projects' research, statistical~~
154 ~~analysis, and quality improvement activities:~~]
155 [~~(A) notwithstanding Subsection 26-33a-108(1) and Section 26-33a-109;~~]
156 [~~(B) contingent upon approval by the committee; and~~]
157 [~~(C) subject to a contract between the department and the entity providing analysis for~~
158 ~~the demonstration project;~~]
159 [~~(iii)~~] (ii) share data regarding insurance claims and an individual's and small employer
160 group's health risk factor with insurers participating in the defined contribution market created
161 in Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, only to the extent
162 necessary for:
163 (A) [~~renewals of policies~~] establishing rates and prospective risk adjusting in the
164 defined contribution arrangement market; and
165 (B) risk adjusting in the defined contribution arrangement market; and
166 [~~(iv)~~] (iii) assist the Legislature and the public with awareness of, and the promotion
167 of, transparency in the health care market by reporting on:
168 (A) geographic variances in medical care and costs as demonstrated by data available
169 to the committee; and
170 (B) rate and price increases by health care providers:
171 (I) that exceed the Consumer Price Index - Medical as provided by the United States
172 Bureau of Labor statistics;
173 (II) as calculated yearly from June to June; and
174 (III) as demonstrated by data available to the committee.
175 (b) The plan adopted under this Subsection (2) shall include:
176 (i) the type of data that will be collected;
177 (ii) how the data will be evaluated;
178 (iii) how the data will be used;
179 (iv) the extent to which, and how the data will be protected; and
180 (v) who will have access to the data.

181 Section 4. Section **26-33a-106.5** is amended to read:
182 **26-33a-106.5. Comparative analyses.**
183 (1) The committee may publish compilations or reports that compare and identify
184 health care providers or data suppliers from the data it collects under this chapter or from any
185 other source.
186 (2) (a) The committee shall publish compilations or reports from the data it collects
187 under this chapter or from any other source which:
188 (i) contain the information described in Subsection (2)(b); and
189 (ii) compare and identify by name at least a majority of the health care facilities and
190 institutions in the state.
191 (b) The report required by this Subsection (2) shall:
192 (i) be published at least annually; and
193 (ii) contain comparisons based on at least the following factors:
194 (A) nationally or other generally recognized quality standards;
195 (B) charges; and
196 (C) nationally recognized patient safety standards.
197 (3) The committee may contract with a private, independent analyst to evaluate the
198 standard comparative reports of the committee that identify, compare, or rank the performance
199 of data suppliers by name. The evaluation shall include a validation of statistical
200 methodologies, limitations, appropriateness of use, and comparisons using standard health
201 services research practice. The analyst shall be experienced in analyzing large databases from
202 multiple data suppliers and in evaluating health care issues of cost, quality, and access. The
203 results of the analyst's evaluation shall be released to the public before the standard
204 comparative analysis upon which it is based may be published by the committee.
205 (4) The committee shall adopt by rule a timetable for the collection and analysis of data
206 from multiple types of data suppliers.
207 (5) The comparative analysis required under Subsection (2) shall be available:
208 (a) free of charge and easily accessible to the public; and
209 (b) on the Health Insurance Exchange either directly or through a link.
210 (6) (a) [~~On or before December 1, 2011, the~~] The department shall include in the report
211 required by Subsection (2)(b), or include in a separate report, comparative information on

212 commonly recognized or generally agreed upon measures of quality identified in accordance
213 with Subsection (7), for:
214 (i) routine and preventive care; and
215 (ii) the treatment of diabetes, heart disease, and other illnesses or conditions.
216 (b) The comparative information required by Subsection (6)(a) shall be based on data
217 collected under Subsection (2) and clinical data that may be available to the committee, and
218 shall [~~be reported as a statewide aggregate for facilities and clinics.~~] beginning on or after July
219 1, 2012, compare:
220 [~~(c) The department shall, in accordance with Subsection (7)(c), publish reports on or~~
221 ~~after July 1, 2012, based on the quality measures described in Subsection (6)(a), using the data~~
222 ~~collected under Subsection (2) and clinical data that may be available to the committee, that~~
223 ~~compare:~~]
224 (i) results for health care facilities or institutions;
225 (ii) a clinic's aggregate results for a physician who practices at a clinic with five or
226 more physicians; and
227 (iii) a geographic region's aggregate results for a physician who practices at a clinic
228 with less than five physicians, unless the physician requests physician-level data to be
229 published on a clinic level.
230 [~~(d)~~] (c) The department:
231 (i) may publish information required by this Subsection (6) directly or through one or
232 more nonprofit, community-based health data organizations;
233 (ii) may use a private, independent analyst under Subsection (3) in preparing the report
234 required by this section; and
235 (iii) shall identify and report to the Legislature's Health and Human Services Interim
236 Committee by July 1, 2012, and every July 1, thereafter until July 1, 2015, at least five new
237 measures of quality to be added to the report each year.
238 [~~(e)~~] (d) A report published by the department under this Subsection (6):
239 (i) is subject to the requirements of Section 26-33a-107; and
240 (ii) shall, prior to being published by the department, be submitted to a neutral,
241 non-biased entity with a broad base of support from health care payers and health care
242 providers in accordance with Subsection (7) for the purpose of validating the report.

243 (7) (a) The Health Data Committee shall, through the department, for purposes of
244 Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral,
245 non-biased entity with a broad base of support from health care payers and health care
246 providers.
247 (b) If the entity described in Subsection (7)(a) does not submit the quality measures
248 [~~prior to July 1, 2011~~], the department may select the appropriate number of quality measures
249 for purposes of the report required by Subsection (6).
250 (c) (i) For purposes of the reports published on or after July 1, 2012, the department
251 may not compare individual facilities or clinics as described in Subsections (6)[~~(c)~~](b)(i)
252 through (iii) if the department determines that the data available to the department can not be
253 appropriately validated, does not represent nationally recognized measures, does not reflect the
254 mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing
255 providers.
256 (ii) The department shall report to the Legislature's Executive Appropriations
257 Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).
258 [~~(d) The committee and the department shall report to the Legislature's Health System~~
259 ~~Reform Task Force on or before November 1, 2011, regarding the department's progress in~~
260 ~~creating a system to validate the data and address the issues described in Subsection(7)(c).~~]
261 Section 5. Section **26-40-106** is amended to read:
262 **26-40-106. Program benefits.**
263 (1) Until the department implements a plan under Subsection (2), program benefits
264 may include:
265 (a) hospital services;
266 (b) physician services;
267 (c) laboratory services;
268 (d) prescription drugs;
269 (e) mental health services;
270 (f) basic dental services;
271 (g) preventive care including:
272 (i) routine physical examinations;
273 (ii) immunizations;

274 (iii) basic vision services; and
275 (iv) basic hearing services;
276 (h) limited home health and durable medical equipment services; and
277 (i) hospice care.
278 (2) (a) Except as provided in Subsection (2)(d), no later than July 1, 2008, the medical
279 program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, to be
280 actuarially equivalent to a health benefit plan with the largest insured commercial enrollment
281 offered by a health maintenance organization in the state.
282 (b) Except as provided in Subsection (2)(d), after July 1, [~~2008~~] 2012:
283 (i) medical program benefits may not exceed the benefit level described in Subsection
284 (2)(a); and
285 (ii) medical program benefits shall be adjusted every July 1, thereafter to meet the
286 benefit level described in Subsection (2)(a).
287 (c) The dental benefit plan shall be benchmarked, in accordance with the Children's
288 Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit
289 plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is
290 offered in the state, except that the utilization review mechanism for orthodontia shall be based
291 on medical necessity. Dental program benefits shall be adjusted on July 1, 2012, and on July 1
292 every three years thereafter to meet the benefit level required by this Subsection (2)(c).
293 (d) The program benefits for enrollees who are at or below 100% of the federal poverty
294 level are exempt from the benchmark requirements of Subsections (2)(a) and (2)(b).
295 Section 6. Section **31A-22-613** is amended to read:
296 **31A-22-613. Permitted provisions for accident and health insurance policies.**
297 The following provisions may be contained in an accident and health insurance policy,
298 but if they are in that policy, they shall conform to at least the minimum requirements for the
299 policyholder in this section.
300 (1) Any provision respecting change of occupation may provide only for a lower
301 maximum benefit payment and for reduction of loss payments proportionate to the change in
302 appropriate premium rates, if the change is to a higher rated occupation, and this provision
303 shall provide for retroactive reduction of premium rates from the date of change of occupation
304 or the last policy anniversary date, whichever is the more recent, if the change is to a lower

305 rated occupation.
306 (2) Section 31A-22-405 applies to misstatement of age in accident and health policies,
307 with the appropriate modifications of terminology.
308 (3) Any policy which contains a provision establishing, as an age limit or otherwise, a
309 date after which the coverage provided by the policy is not effective, and if that date falls
310 within a period for which a premium is accepted by the insurer or if the insurer accepts a
311 premium after that date, the coverage provided by the policy continues in force, subject to any
312 right of cancellation, until the end of the period for which the premium was accepted. This
313 Subsection (3) does not apply if the acceptance of premium would not have occurred but for a
314 misstatement of age by the insured.
315 (4) (a) If an insured is otherwise eligible for maternity benefits, a policy may not
316 contain language which requires an insured to obtain any additional preauthorization or
317 preapproval for customary and reasonable maternity care expenses or for the delivery of the
318 child after an initial preauthorization or preapproval has been obtained from the insurer for
319 prenatal care. A requirement for notice of admission for delivery is not a requirement for
320 preauthorization or preapproval, however, the maternity benefit may not be denied or
321 diminished for failure to provide admission notice. The policy may not require the provision of
322 admission notice by only the insured patient.
323 (b) This Subsection (4) does not prohibit an insurer from:
324 (i) requiring a referral before maternity care can be obtained;
325 (ii) specifying a group of providers or a particular location from which an insured is
326 required to obtain maternity care; or
327 (iii) limiting reimbursement for maternity expenses and benefits in accordance with the
328 terms and conditions of the insurance contract so long as such terms do not conflict with
329 Subsection (4)(a).
330 (5) <u>(a)</u> An insurer may only represent that a policy[~~: (a)~~] offers a vision benefit if the
331 policy[~~: (i) charges a premium for the benefit; and (ii)~~] provides reimbursement for materials
332 or services provided under the policy[~~; and~~]<u>.</u>
333 (b) <u>An insurer may only represent that a policy</u> covers laser vision correction, whether
334 photorefractive keratectomy, laser assisted in-situ keratomelusis, or related procedure, if [~~the~~
335 ~~policy: (i) charges a premium for the benefit; and (ii)~~] the procedure is at least a partially

336 covered benefit.

337 (6) If a policy excludes coverage for the diagnosis and treatment of autism spectrum
338 disorders, the insurer may not deny a claim for a procedure or service that is otherwise covered
339 in the accident and health insurance policy Ŝ→ [~~based on the diagnosis of an autism spectrum~~
340 ~~disorder,~~] ←Ŝ unless the Ŝ→ **autism spectrum disorder is the primary diagnosis or reason for**
340a **the service or procedure in the** ←Ŝ particular claim Ŝ→ [~~is directly related to the autism spectrum~~
340b ~~disorder~~] ←Ŝ .

341 Section 7. Section **31A-22-613.5** is amended to read:

342 **31A-22-613.5. Price and value comparisons of health insurance.**

343 (1) (a) This section applies to all health benefit plans.
344 (b) Subsection (2) applies to:
345 (i) all health benefit plans; and
346 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
347 (2) (a) The commissioner shall promote informed consumer behavior and responsible
348 health benefit plans by requiring an insurer issuing a health benefit plan to:
349 (i) provide to all enrollees, prior to enrollment in the health benefit plan written
350 disclosure of:
351 (A) restrictions or limitations on prescription drugs and biologics including:
352 (I) the use of a formulary;
353 (II) co-payments and deductibles for prescription drugs; and
354 (III) requirements for generic substitution;
355 (B) coverage limits under the plan; and
356 (C) any limitation or exclusion of coverage including:
357 (I) a limitation or exclusion for a secondary medical condition related to a limitation or
358 exclusion from coverage; and
359 (II) easily understood examples of a limitation or exclusion of coverage for a secondary
360 medical condition; and
361 (ii) provide the commissioner with:
362 (A) the information described in Subsections 31A-22-635(5) through (7) in the
363 standardized electronic format required by Subsection 63M-1-2506(1); and
364 (B) information regarding insurer transparency in accordance with Subsection (4).
365 (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to
366 the commissioner:

367 (i) upon commencement of operations in the state; and
368 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
369 (A) treatment policies;
370 (B) practice standards;
371 (C) restrictions;
372 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
373 (E) limitations or exclusions of coverage including a limitation or exclusion for a
374 secondary medical condition related to a limitation or exclusion of the insurer's health
375 insurance plan.
376 (c) An insurer shall provide the enrollee with notice of an increase in costs for
377 prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):
378 (i) either:
379 (A) in writing; or
380 (B) on the insurer's website; and
381 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
382 soon as reasonably possible.
383 (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make
384 available to prospective enrollees and maintain evidence of the fact of the disclosure of:
385 (i) the drugs included;
386 (ii) the patented drugs not included;
387 (iii) any conditions that exist as a precedent to coverage; and
388 (iv) any exclusion from coverage for secondary medical conditions that may result
389 from the use of an excluded drug.
390 (e) (i) The commissioner shall develop examples of limitations or exclusions of a
391 secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).
392 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
393 (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact
394 situation to fall within the description of an example does not, by itself, support a finding of
395 coverage.
396 (3) The commissioner:
397 (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to

398 the Health Insurance Exchange created under Section 63M-1-2504; and
399 (b) may request information from an insurer to verify the information submitted by the
400 insurer under this section.
401 (4) The commissioner shall:
402 (a) convene a group of insurers, a member representing the Public Employees' Benefit
403 and Insurance Program, consumers, and an organization [~~described in Subsection~~
404 ~~31A-22-614.6(3)(b)~~] that provides multipayer and multiprovider quality assurance and data
405 collection, to develop information for consumers to compare health insurers and health benefit
406 plans on the Health Insurance Exchange, which shall include consideration of:
407 (i) the number and cost of an insurer's denied health claims;
408 (ii) the cost of denied claims that is transferred to providers;
409 (iii) the average out-of-pocket expenses incurred by participants in each health benefit
410 plan that is offered by an insurer in the Health Insurance Exchange;
411 (iv) the relative efficiency and quality of claims administration and other administrative
412 processes for each insurer offering plans in the Health Insurance Exchange; and
413 (v) consumer assessment of each insurer or health benefit plan;
414 (b) adopt an administrative rule that establishes:
415 (i) definition of terms;
416 (ii) the methodology for determining and comparing the insurer transparency
417 information;
418 (iii) the data, and format of the data, that an insurer shall submit to the commissioner in
419 order to facilitate the consumer comparison on the Health Insurance Exchange in accordance
420 with Section 63M-1-2506; and
421 (iv) the dates on which the insurer shall submit the data to the commissioner in order
422 for the commissioner to transmit the data to the Health Insurance Exchange in accordance with
423 Section 63M-1-2506; and
424 (c) implement the rules adopted under Subsection (4)(b) in a manner that protects the
425 business confidentiality of the insurer.
426 Section 8. Section **31A-22-635** is amended to read:
427 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**
428 **on Health Insurance Exchange.**

429 (1) For purposes of this section, "insurer":
430 (a) is defined in Subsection 31A-22-634(1); and
431 (b) includes the state employee's risk pool under Section 49-20-202.
432 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall
433 use a uniform application form.
434 (b) The uniform application form:
435 (i) except for cancer and transplants, may not include questions about an applicant's
436 health history prior to the previous five years; and
437 (ii) shall be shortened and simplified in accordance with rules adopted by the
438 commissioner.
439 (c) Insurers offering a health benefit plan to a small employer shall use a uniform
440 waiver of coverage form, which may not include health status related questions other than
441 pregnancy, and is limited to:
442 (i) information that identifies the employee;
443 (ii) proof of the employee's insurance coverage; and
444 (iii) a statement that the employee declines coverage with a particular employer group.
445 (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and
446 uniform waiver of coverage forms may be combined or modified to facilitate a more efficient
447 and consumer friendly experience for enrollees using the Health Insurance Exchange if the
448 modification is approved by the commissioner.
449 (4) The uniform application form, and uniform waiver form, shall be adopted and
450 approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
451 Rulemaking Act.
452 (5) (a) An insurer who offers a health benefit plan in either the group or individual
453 market on the Health Insurance Exchange created in Section 63M-1-2504, shall:
454 (i) accept and process an electronic submission of the uniform application or uniform
455 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
456 Section 63M-1-2506;
457 (ii) if requested, provide the applicant with a copy of the completed application either
458 by mail or electronically;
459 (iii) post all health benefit plans offered by the insurer in the defined contribution

460 arrangement market on the Health Insurance Exchange; and
461 (iv) post the information required by Subsection (6) on the Health Insurance Exchange
462 for every health benefit plan the insurer offers on the Health Insurance Exchange.
463 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans
464 on the Health Insurance Exchange may not directly or indirectly offer products on the Health
465 Insurance Exchange that are not health benefit plans.
466 (c) Notwithstanding Subsection (5)(b)[,]:
467 (i) an insurer may offer a health savings account on the Health Insurance Exchange[.];
468 and
469 (ii) an insurer may offer dental and vision plans on the Health Insurance Exchange if:
470 (A) the department determines, after study and consultation with the Health System
471 Reform Task Force, that the department is able to establish standards for dental and vision
472 policies offered on the health insurance exchange, and the department determines whether a
473 risk adjuster mechanism is necessary for a defined contribution vision and dental plan market
474 on the Health Insurance Exchange; and
475 (B) the department, in accordance with recommendations from the Health System
476 Reform Task Force, adopts administrative rules to regulate the offer of dental and vision plans
477 on the Health Insurance Exchange.
478 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with
479 the following information for each health benefit plan submitted to the Health Insurance
480 Exchange, in the electronic format required by Subsection 63M-1-2506(1):
481 (a) plan design, benefits, and options offered by the health benefit plan including state
482 mandates the plan does not cover;
483 (b) information and Internet address to online provider networks;
484 (c) wellness programs and incentives;
485 (d) descriptions of prescription drug benefits, exclusions, or limitations;
486 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is
487 submitted to the insurer for the prior year; and
488 (f) the claims denial and insurer transparency information developed in accordance
489 with Subsection 31A-22-613.5(4).
490 (7) The Insurance Department shall post on the Health Insurance Exchange the

491 Insurance Department's solvency rating for each insurer who posts a health benefit plan on the
492 Health Insurance Exchange. The solvency rating for each insurer shall be based on
493 methodology established by the Insurance Department by administrative rule and shall be
494 updated each calendar year.
495 (8) (a) The commissioner may request information from an insurer under Section
496 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health
497 Insurance Exchange.
498 (b) The commissioner shall regulate any fees charged by insurers to an enrollee for a
499 uniform application form or electronic submission of the application forms.
500 Section 9. Section **31A-23a-402.5** is amended to read:
501 **31A-23a-402.5. Inducements.**
502 (1) (a) Except as provided in Subsection (2), a licensee under this title, or an officer or
503 employee of a licensee, may not induce a person to enter into, continue, or terminate an
504 insurance contract by offering a benefit that is not:
505 (i) specified in the insurance contract; or
506 (ii) directly related to the insurance contract.
507 (b) An insurer may not make or knowingly allow an agreement of insurance that is not
508 clearly expressed in the insurance contract to be issued or renewed.
509 (c) A licensee under this title may not absorb the tax under Section 31A-3-301.
510 (2) This section does not apply to a title insurer, a title producer, or an officer or
511 employee of a title insurer or title producer.
512 (3) Items not prohibited by Subsection (1) include an insurer:
513 (a) reducing premiums because of expense savings;
514 (b) providing to a policyholder or insured one or more incentives, as defined by the
515 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
516 Rulemaking Act, to participate in a program or activity designed to reduce claims or claim
517 expenses[~~; or~~], including:
518 (i) a premium discount offered to a small or large employer group based on a wellness
519 program if:
520 (A) the premium discount for the employer group does not exceed 20% of the group
521 premium; and

522 (B) the premium discount based on the wellness program is offered uniformly by the
523 insurer to all employer groups in the large or small group market;
524 (ii) a premium discount offered to employees of a small or large employer group in an
525 amount that does not exceed federal limits on wellness program incentives; or
526 (iii) a combination of premium discounts offered to the employer group and the
527 employees of an employer group, based on a wellness program, if:
528 (A) the premium discounts for the employer group comply with Subsection (3)(b)(i);
529 and
530 (B) the premium discounts for the employees of an employer group comply with
531 Subsection (3)(b)(ii); or
532 (c) receiving premiums under an installment payment plan.
533 (4) Items not prohibited by Subsection (1) include a licensee, or an officer or employee
534 of a licensee, either directly or through a third party:
535 (a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not
536 conditioned on the purchase of a particular insurance product;
537 (b) extending credit on a premium to the insured:
538 (i) without interest, for no more than 90 days from the effective date of the insurance
539 contract;
540 (ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid
541 balance after the time period described in Subsection (4)(b)(i); and
542 (iii) except that an installment or payroll deduction payment of premiums on an
543 insurance contract issued under an insurer's mass marketing program is not considered an
544 extension of credit for purposes of this Subsection (4)(b);
545 (c) preparing or conducting a survey that:
546 (i) is directly related to an accident and health insurance policy purchased from the
547 licensee; or
548 (ii) is used by the licensee to assess the benefit needs and preferences of insureds,
549 employers, or employees directly related to an insurance product sold by the licensee;
550 (d) providing limited human resource services that are directly related to an insurance
551 product sold by the licensee, including:
552 (i) answering questions directly related to:

553 (A) an employee benefit offering or administration, if the insurance product purchased
554 from the licensee is accident and health insurance or health insurance; and
555 (B) employment practices liability, if the insurance product purchased from the
556 licensee is property or casualty insurance; and
557 (ii) providing limited human resource compliance training and education directly
558 pertaining to an insurance product purchased from the licensee;
559 (e) providing the following types of information or guidance:
560 (i) providing guidance directly related to compliance with federal and state laws for an
561 insurance product purchased from the licensee;
562 (ii) providing a workshop or seminar addressing an insurance issue that is directly
563 related to an insurance product purchased from the licensee; or
564 (iii) providing information regarding:
565 (A) employee benefit issues;
566 (B) directly related insurance regulatory and legislative updates; or
567 (C) similar education about an insurance product sold by the licensee and how the
568 insurance product interacts with tax law;
569 (f) preparing or providing a form that is directly related to an insurance product
570 purchased from, or offered by, the licensee;
571 (g) preparing or providing documents directly related to a flexible spending account,
572 but not providing ongoing administration of a flexible spending account;
573 (h) providing enrollment and billing assistance, including:
574 (i) providing benefit statements or new hire insurance benefits packages; and
575 (ii) providing technology services such as an electronic enrollment platform or
576 application system;
577 (i) communicating coverages in writing and in consultation with the insured and
578 employees;
579 (j) providing employee communication materials and notifications directly related to an
580 insurance product purchased from a licensee;
581 (k) providing claims management and resolution to the extent permitted under the
582 licensee's license;
583 (l) providing underwriting or actuarial analysis or services;

584 (m) negotiating with an insurer regarding the placement and pricing of an insurance
585 product;
586 (n) recommending placement and coverage options;
587 (o) providing a health fair or providing assistance or advice on establishing or
588 operating a wellness program, but not providing any payment for or direct operation of the
589 wellness program;
590 (p) providing COBRA and Utah mini-COBRA administration, consultations, and other
591 services directly related to an insurance product purchased from the licensee;
592 (q) assisting with a summary plan description;
593 (r) providing information necessary for the preparation of documents directly related to
594 the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as
595 amended;
596 (s) providing information or services directly related to the Health Insurance Portability
597 and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services
598 directly related to health care access, portability, and renewability when offered in connection
599 with accident and health insurance sold by a licensee;
600 (t) sending proof of coverage to a third party with a legitimate interest in coverage;
601 (u) providing information in a form approved by the commissioner and directly related
602 to determining whether an insurance product sold by the licensee meets the requirements of a
603 third party contract that requires or references insurance coverage;
604 (v) facilitating risk management services directly related to the insurance product sold
605 or offered for sale by the licensee, including:
606 (i) risk management;
607 (ii) claims and loss control services; and
608 (iii) risk assessment consulting;
609 (w) otherwise providing services that are legitimately part of servicing an insurance
610 product purchased from a licensee; and
611 (x) providing other directly related services approved by the department.
612 (5) An inducement prohibited under Subsection (1) includes a licensee, or an officer or
613 employee of a licensee:
614 (a) (i) providing a premium or commission rebate;

615 (ii) paying the salary of an employee of a person who purchases an insurance product
616 from the licensee; or
617 (iii) if the licensee is an insurer, or a third party administrator who contracts with an
618 insurer, paying the salary for an onsite staff member to perform an act prohibited under
619 Subsection (5)(b)(xii); or
620 (b) engaging in one or more of the following unless a fee is paid in accordance with
621 Subsection (7):
622 (i) performing background checks of prospective employees;
623 (ii) providing legal services by a person licensed to practice law;
624 (iii) performing drug testing that is directly related to an insurance product purchased
625 from the licensee;
626 (iv) preparing employer or employee handbooks, except that a licensee may:
627 (A) provide information for a medical benefit section of an employee handbook;
628 (B) provide information for the section of an employee handbook directly related to an
629 employment practices liability insurance product purchased from the licensee; or
630 (C) prepare or print an employee benefit enrollment guide;
631 (v) providing job descriptions, postings, and applications for a person that purchases an
632 employment practices liability insurance product from the licensee;
633 (vi) providing payroll services;
634 (vii) providing performance reviews or performance review training;
635 (viii) providing union advice;
636 (ix) providing accounting services;
637 (x) providing data analysis information technology programs, except as provided in
638 Subsection (4)(h)(ii);
639 (xi) providing administration of health reimbursement accounts or health savings
640 accounts; or
641 (xii) if the licensee is an insurer, or a third party administrator who contracts with an
642 insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of
643 the following prohibited benefits:
644 (A) performing background checks of prospective employees;
645 (B) providing legal services by a person licensed to practice law;

646 (C) performing drug testing that is directly related to an insurance product purchased
647 from the insurer;
648 (D) preparing employer or employee handbooks;
649 (E) providing job descriptions postings, and applications;
650 (F) providing payroll services;
651 (G) providing performance reviews or performance review training;
652 (H) providing union advice;
653 (I) providing accounting services;
654 (J) providing discrimination testing; or
655 (K) providing data analysis information technology programs.
656 (6) A de minimis gift or meal not to exceed $25 for each individual receiving the gift
657 or meal is presumed to be a social courtesy not conditioned on the purchase of a particular
658 insurance product for purposes of Subsection (4)(a).
659 (7) If as provided under Subsection (5)(b) a licensee is paid a fee to provide an item
660 listed in Subsection (5)(b), the licensee shall comply with Subsection 31A-23a-501(2) in
661 charging the fee, except that the fee paid for the item shall equal or exceed the fair market
662 value of the item.
663 Section 10. Section **31A-23a-501** is amended to read:
664 **31A-23a-501. Licensee compensation.**
665 (1) As used in this section:
666 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
667 licensee from:
668 (i) commission amounts deducted from insurance premiums on insurance sold by or
669 placed through the licensee; or
670 (ii) commission amounts received from an insurer or another licensee as a result of the
671 sale or placement of insurance.
672 (b) (i) "Compensation from an insurer or third party administrator" means
673 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
674 gifts, prizes, or any other form of valuable consideration:
675 (A) whether or not payable pursuant to a written agreement; and
676 (B) received from:

677 (I) an insurer; or
678 (II) a third party to the transaction for the sale or placement of insurance.
679 (ii) "Compensation from an insurer or third party administrator" does not mean
680 compensation from a customer that is:
681 (A) a fee or pass-through costs as provided in Subsection (1)(e); or
682 (B) a fee or amount collected by or paid to the producer that does not exceed an
683 amount established by the commissioner by administrative rule.
684 (c) (i) "Customer" means:
685 (A) the person signing the application or submission for insurance; or
686 (B) the authorized representative of the insured actually negotiating the placement of
687 insurance with the producer.
688 (ii) "Customer" does not mean a person who is a participant or beneficiary of:
689 (A) an employee benefit plan; or
690 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
691 negotiated by the producer or affiliate.
692 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
693 benefit of a licensee other than commission compensation.
694 (ii) "Noncommission compensation" does not include charges for pass-through costs
695 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.
696 (e) "Pass-through costs" include:
697 (i) costs for copying documents to be submitted to the insurer; and
698 (ii) bank costs for processing cash or credit card payments.
699 (2) A licensee may receive from an insured or from a person purchasing an insurance
700 policy, noncommission compensation if the noncommission compensation is stated on a
701 separate, written disclosure.
702 (a) The disclosure required by this Subsection (2) shall:
703 (i) include the signature of the insured or prospective insured acknowledging the
704 noncommission compensation;
705 (ii) clearly specify the amount or extent of the noncommission compensation; and
706 (iii) be provided to the insured or prospective insured before the performance of the
707 service.

708 (b) Noncommission compensation shall be:
709 (i) limited to actual or reasonable expenses incurred for services; and
710 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
711 business or for a specific service or services.
712 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained
713 by any licensee who collects or receives the noncommission compensation or any portion of
714 the noncommission compensation.
715 (d) All accounting records relating to noncommission compensation shall be
716 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.
717 (3) (a) A licensee may receive noncommission compensation when acting as a
718 producer for the insured in connection with the actual sale or placement of insurance if:
719 (i) the producer and the insured have agreed on the producer's noncommission
720 compensation; and
721 (ii) the producer has disclosed to the insured the existence and source of any other
722 compensation that accrues to the producer as a result of the transaction.
723 (b) The disclosure required by this Subsection (3) shall:
724 (i) include the signature of the insured or prospective insured acknowledging the
725 noncommission compensation;
726 (ii) clearly specify the amount or extent of the noncommission compensation and the
727 existence and source of any other compensation; and
728 (iii) be provided to the insured or prospective insured before the performance of the
729 service.
730 (c) The following additional noncommission compensation is authorized:
731 (i) compensation received by a producer of a compensated corporate surety who under
732 procedures approved by a rule or order of the commissioner is paid by surety bond principal
733 debtors for extra services;
734 (ii) compensation received by an insurance producer who is also licensed as a public
735 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
736 claim adjustment, so long as the producer does not receive or is not promised compensation for
737 aiding in the claim adjustment prior to the occurrence of the claim;
738 (iii) compensation received by a consultant as a consulting fee, provided the consultant

739 complies with the requirements of Section 31A-23a-401; or
740 (iv) other compensation arrangements approved by the commissioner after a finding
741 that they do not violate Section 31A-23a-401 and are not harmful to the public.
742 (4) (a) For purposes of this Subsection (4), "producer" includes:
743 (i) a producer;
744 (ii) an affiliate of a producer; or
745 (iii) a consultant.
746 (b) [~~Beginning January 1, 2010, in addition to any other disclosures required by this~~
747 ~~section, a~~] A producer may not accept or receive any compensation from an insurer or third
748 party administrator for the initial placement of a health benefit plan, other than a hospital
749 confinement indemnity policy, unless prior to the customer's initial purchase of the health
750 benefit plan the producer[~~: (i) except as provided in Subsection (4)(c),~~] discloses in writing to
751 the customer that the producer will receive compensation from the insurer or third party
752 administrator for the placement of insurance, including the amount or type of compensation
753 known to the producer at the time of the disclosure[~~; and~~].
754 [~~(ii) except as provided in Subsection (4)(c):~~]
755 [~~(A) obtains~~] (c) A producer shall:
756 (i) obtain the customer's signed acknowledgment that the disclosure under Subsection
757 (4)(b)[~~(i)~~] was made to the customer; or
758 [~~(B) (I) signs~~] (ii) (A) sign a statement that the disclosure required by Subsection
759 (4)(b)[~~(i)~~] was made to the customer; and
760 [~~(II) keeps~~] (B) keep the signed statement on file in the producer's office while the
761 health benefit plan placed with the customer is in force.
762 [~~(c) If the compensation to the producer from an insurer or third party administrator is~~
763 ~~for the renewal of a health benefit plan, once the producer has made an initial disclosure that~~
764 ~~complies with Subsection (4)(b), the producer does not have to disclose compensation received~~
765 ~~for the subsequent yearly renewals in accordance with Subsection (4)(b) until the renewal~~
766 ~~period immediately following 36 months after the initial disclosure.~~]
767 (d) (i) A licensee who collects or receives any part of the compensation from an insurer
768 or third party administrator in a manner that facilitates an audit shall, while the health benefit
769 plan placed with the customer is in force, maintain a copy of:

770 (A) the signed acknowledgment described in Subsection (4)[~~(b)(i)~~](c)(i); or
771 (B) the signed statement described in Subsection (4)[~~(b)(ii)~~](c)(ii).
772 (ii) The standard application developed in accordance with Section 31A-22-635 shall
773 include a place for a producer to provide the disclosure required by this Subsection (4), and if
774 completed, shall satisfy the requirement of Subsection (4)(d)(i).
775 (e) Subsection (4)[~~(b)(ii)~~](c) does not apply to:
776 (i) a person licensed as a producer who acts only as an intermediary between an insurer
777 and the customer's producer, including a managing general agent; or
778 (ii) the placement of insurance in a secondary or residual market.
779 (5) This section does not alter the right of any licensee to recover from an insured the
780 amount of any premium due for insurance effected by or through that licensee or to charge a
781 reasonable rate of interest upon past-due accounts.
782 (6) This section does not apply to bail bond producers or bail enforcement agents as
783 defined in Section 31A-35-102.
784 (7) A licensee may not receive noncommission compensation from an insured or
785 enrollee for providing a service or engaging in an act that is required to be provided or
786 performed in order to receive commission compensation, except for the surplus lines
787 transactions that do not receive commissions.
788 Section 11. Section **31A-30-106.1** is amended to read:
789 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**
790 (1) Premium rates for small employer health benefit plans under this chapter are
791 subject to this section.
792 (2) (a) The index rate for a rating period for any class of business may not exceed the
793 index rate for any other class of business by more than 20%.
794 (b) For a class of business, the premium rates charged during a rating period to covered
795 insureds with similar case characteristics for the same or similar coverage, or the rates that
796 could be charged to an employer group under the rating system for that class of business, may
797 not vary from the index rate by more than 30% of the index rate, except when catastrophic
798 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).
799 (3) The percentage increase in the premium rate charged to a covered insured for a new
800 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of

801 the following:
802 (a) the percentage change in the new business premium rate measured from the first
803 day of the prior rating period to the first day of the new rating period;
804 (b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
805 of less than one year, due to the claim experience, health status, or duration of coverage of the
806 covered individuals as determined from the small employer carrier's rate manual for the class of
807 business, except when catastrophic mental health coverage is selected as provided in
808 Subsection 31A-22-625(2)(d); and
809 (c) any adjustment due to change in coverage or change in the case characteristics of
810 the covered insured as determined for the class of business from the small employer carrier's
811 rate manual.
812 (4) (a) Adjustments in rates for claims experience, health status, and duration from
813 issue may not be charged to individual employees or dependents.
814 (b) Rating adjustments and factors, including case characteristics, shall be applied
815 uniformly and consistently to the rates charged for all employees and dependents of the small
816 employer.
817 (c) Rating factors shall produce premiums for identical groups that:
818 (i) differ only by the amounts attributable to plan design; and
819 (ii) do not reflect differences due to the nature of the groups assumed to select
820 particular health benefit products.
821 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the
822 same calendar month as having the same rating period.
823 (5) A health benefit plan that uses a restricted network provision may not be considered
824 similar coverage to a health benefit plan that does not use a restricted network provision,
825 provided that use of the restricted network provision results in substantial difference in claims
826 costs.
827 (6) The small employer carrier may not use case characteristics other than the
828 following:
829 (a) age of the employee, in accordance with Subsection (7);
830 (b) geographic area;
831 (c) family composition in accordance with Subsection (9);

832 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee and
833 spouse; [~~and~~]
834 (e) for an individual age 65 and older, whether the employer policy is primary or
835 secondary to Medicare[~~.~~]; and
836 (f) a wellness program, in accordance with Subsection (12).
837 (7) Age limited to:
838 (a) the following age bands:
839 (i) less than 20;
840 (ii) 20-24;
841 (iii) 25-29;
842 (iv) 30-34;
843 (v) 35-39;
844 (vi) 40-44;
845 (vii) 45-49;
846 (viii) 50-54;
847 (ix) 55-59;
848 (x) 60-64; and
849 (xi) 65 and above; and
850 (b) a standard slope ratio range for each age band, applied to each family composition
851 tier rating structure under Subsection (9)(b):
852 (i) as developed by the commissioner by administrative rule; and
853 (ii) not to exceed an overall ratio as provided in Subsection (8).
854 (8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:
855 (i) 5:1 for plans renewed or effective before January 1, 2012; and
856 (ii) 6:1 for plans renewed or effective on or after January 1, 2012; and
857 (b) the age slope ratios for each age band may not overlap.
858 (9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:
859 (a) an overall ratio of:
860 (i) 5:1 or less for plans renewed or effective before January 1, 2012; and
861 (ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and
862 (b) a tier rating structure that includes:

863 (i) four tiers that include:
864 (A) employee only;
865 (B) employee plus spouse;
866 (C) employee plus a child or children; and
867 (D) a family, consisting of an employee plus spouse, and a child or children;
868 (ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:
869 (A) employee only;
870 (B) employee plus spouse;
871 (C) employee plus one child;
872 (D) employee plus two or more children; and
873 (E) employee plus spouse plus one or more children; or
874 (iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:
875 (A) employee only;
876 (B) employee plus spouse;
877 (C) employee plus one child;
878 (D) employee plus two or more children;
879 (E) employee plus spouse plus one child; and
880 (F) employee plus spouse plus two or more children.
881 (10) If a health benefit plan is a health benefit plan into which the small employer
882 carrier is no longer enrolling new covered insureds, the small employer carrier shall use the
883 percentage change in the base premium rate, provided that the change does not exceed, on a
884 percentage basis, the change in the new business premium rate for the most similar health
885 benefit product into which the small employer carrier is actively enrolling new covered
886 insureds.
887 (11) (a) A covered carrier may not transfer a covered insured involuntarily into or out
888 of a class of business.
889 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
890 of business unless the offer is made to transfer all covered insureds in the class of business
891 without regard to:
892 (i) case characteristics;
893 (ii) claim experience;

894 (iii) health status; or
895 (iv) duration of coverage since issue.
896 (12) Notwithstanding Subsection (4)(b), a small employer carrier may:
897 (a) offer a wellness program to a small employer group if:
898 (i) the premium discount to the employer for the wellness program does not exceed
899 20% of the premium for the small employer group; and
900 (ii) the carrier offers the wellness program discount uniformly across all small
901 employer groups;
902 (b) offer a premium discount as part of a wellness program to individual employees in
903 a small employer group:
904 (i) to the extent allowed by federal law; and
905 (ii) if the employee discount based on the wellness program is offered uniformly across
906 all small employer groups; and
907 (c) offer a combination of premium discounts for the employer and the employee,
908 based on a wellness program, if:
909 (i) the employer discount complies with Subsection (12)(a); and
910 (ii) the employee discount complies with Subsection (12)(b).
911 [(12)] (13) (a) Each small employer carrier shall maintain at the small employer
912 carrier's principal place of business a complete and detailed description of its rating practices
913 and renewal underwriting practices, including information and documentation that demonstrate
914 that the small employer carrier's rating methods and practices are:
915 (i) based upon commonly accepted actuarial assumptions; and
916 (ii) in accordance with sound actuarial principles.
917 (b) (i) Each small employer carrier shall file with the commissioner on or before April
918 1 of each year, in a form and manner and containing information as prescribed by the
919 commissioner, an actuarial certification certifying that:
920 (A) the small employer carrier is in compliance with this chapter; and
921 (B) the rating methods of the small employer carrier are actuarially sound.
922 (ii) A copy of the certification required by Subsection [(12)] (13)(b)(i) shall be retained
923 by the small employer carrier at the small employer carrier's principal place of business.
924 (c) A small employer carrier shall make the information and documentation described

925 in this Subsection [~~(12)~~] (13) available to the commissioner upon request.
926 [~~(13)~~] (14) (a) The commissioner shall establish rules in accordance with Title 63G,
927 Chapter 3, Utah Administrative Rulemaking Act, to:
928 (i) implement this chapter; and
929 (ii) assure that rating practices used by small employer carriers under this section and
930 carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this
931 chapter.
932 (b) The rules may:
933 (i) assure that differences in rates charged for health benefit plans by carriers are
934 reasonable and reflect objective differences in plan design, not including differences due to the
935 nature of the groups or individuals assumed to select particular health benefit plans; and
936 (ii) prescribe the manner in which case characteristics may be used by small employer
937 and individual carriers.
938 [~~(14)~~] (15) Records submitted to the commissioner under this section shall be
939 maintained by the commissioner as protected records under Title 63G, Chapter 2, Government
940 Records Access and Management Act.
941 Section 12. Section **31A-30-116** is enacted to read:
942 **31A-30-116. Essential health benefits.**
943 (1) For purposes of this section, the "Affordable Care Act" is as defined in Section
944 31A-2-212 and includes federal rules related to the offering of essential health benefits.
945 (2) The state chooses to designate its own essential health benefits rather than accept a
946 federal determination of the essential health benefits required to be offered in the individual
947 and small group market for plans renewed or offered on or after January 1, 2014.
948 (3) (a) Subject to Subsections (3)(b) and (c), to the extent required by the Affordable
949 Care Act, and after considering public testimony, the Legislature's Health System Reform Task
950 Force shall recommend to the commissioner, no later than September 1, 2012, a benchmark
951 plan for the state's essential health benefits based on:
952 (i) the largest plan by enrollment in any of the three largest small employer group
953 insurance products in the state's small employer group market;
954 (ii) any of the largest three state employee health benefit plans by enrollment;
955 (iii) the largest insured commercial non-Medicaid health maintenance organization

956 operating in the state; or
957 (iv) other benchmarks required or permitted by the Affordable Care Act.
958 (b) Notwithstanding the provisions of Subsection 63M-1-2505.5(2), based on the
959 recommendation of the task force under Subsection (3)(a), and within 30 days of the task force
960 recommendation, the commissioner shall adopt an emergency administrative rule that
961 designates the essential health benefits that shall be included in a plan offered or renewed on or
962 after January 1, 2014, in the small employer group and individual markets.
963 (c) The essential health benefit plan:
964 (i) shall not include a state mandate if the inclusion of the state mandate would require
965 the state to contribute to premium subsidies under the Affordable Care Act; and
966 (ii) may add benefits in addition to the benefits included in a benchmark plan described
967 in Subsection (3)(b) if the additional benefits are mandated under the Affordable Care Act.
968 Section 13. Section **63I-2-231** is amended to read:
969 **63I-2-231. Repeal dates, Title 31A.**
970 Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed [~~January 1,~~
971 ~~2013~~] July 1, 2013.
972 Section 14. Section **63M-1-2504** is amended to read:
973 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
974 (1) There is created within the Governor's Office of Economic Development the Office
975 of Consumer Health Services.
976 (2) The office shall:
977 (a) in cooperation with the Insurance Department, the Department of Health, and the
978 Department of Workforce Services, and in accordance with the electronic standards developed
979 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:
980 (i) provides information to consumers about private and public health programs for
981 which the consumer may qualify;
982 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
983 on the Health Insurance Exchange; and
984 (iii) includes information and a link to enrollment in premium assistance programs and
985 other government assistance programs;
986 (b) contract with one or more private vendors for:

987 (i) administration of the enrollment process on the Health Insurance Exchange,
988 including establishing a mechanism for consumers to compare health benefit plan features on
989 the exchange and filter the plans based on consumer preferences;
990 (ii) the collection of health insurance premium payments made for a single policy by
991 multiple payers, including the policyholder, one or more employers of one or more individuals
992 covered by the policy, government programs, and others; and
993 (iii) establishing a call center in accordance with Subsection (3);
994 (c) assist employers with a free or low cost method for establishing mechanisms for the
995 purchase of health insurance by employees using pre-tax dollars;
996 (d) establish a list on the Health Insurance Exchange of insurance producers who, in
997 accordance with Section 31A-30-209, are appointed producers for the Health Insurance
998 Exchange; and
999 (e) report to the Business and Labor Interim Committee and the Health System Reform
1000 Task Force [~~prior to November 1, 2011, and~~] prior to the Legislative interim day in November
1001 of each year [~~thereafter~~] regarding the operations of the Health Insurance Exchange required by
1002 this chapter.
1003 (3) A call center established by the office:
1004 (a) shall provide unbiased answers to questions concerning exchange operations, and
1005 plan information, to the extent the plan information is posted on the exchange by the insurer;
1006 and
1007 (b) may not:
1008 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;
1009 (ii) [~~beginning July 1, 2011,~~] receive producer compensation through the Health
1010 Insurance Exchange; and
1011 (iii) [~~beginning July 1, 2011,~~] be designated as the default producer for an employer
1012 group that enters the Health Insurance Exchange without a producer.
1013 (4) The office:
1014 (a) may not:
1015 (i) regulate health insurers, health insurance plans, health insurance producers, or
1016 health insurance premiums charged in the exchange;
1017 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

1018 (iii) act as an appeals entity for resolving disputes between a health insurer and an
1019 insured;
1020 (b) may establish and collect a fee for the cost of the exchange transaction in
1021 accordance with Section 63J-1-504 for:
1022 [(i) the transaction cost of:]
1023 [(A)] (i) processing an application for a health benefit plan;
1024 [(B)] (ii) accepting, processing, and submitting multiple premium payment sources;
1025 [and]
1026 [(C)] (iii) providing a mechanism for consumers to filter and compare health benefit
1027 plans in the exchange based on consumer preferences; and
1028 [(ii)] (iv) funding the call center [established in accordance with Subsection (3)]; and
1029 (c) shall separately itemize [any fees] the fee established under Subsection (4)(b) as
1030 part of the cost displayed for the employer selecting coverage on the exchange.
1031 Section 15. **Repealer.**
1032 This bill repeals:
1033 Section **26-1-39, Health System Reform Demonstration Projects.**
1034 Section **31A-22-614.6, Health care delivery and payment reform demonstration**
1035 **projects.**
1036 Section 16. **Health System Reform Task Force -- Creation -- Membership --**
1037 **Interim rules followed -- Compensation -- Staff.**
1038 (1) There is created the Health System Reform Task Force consisting of the following
1039 11 members:
1040 (a) four members of the Senate appointed by the president of the Senate, no more than
1041 three of whom may be from the same political party; and
1042 (b) seven members of the House of Representatives appointed by the speaker of the
1043 House of Representatives, no more than five of whom may be from the same political party.
1044 (2) (a) The president of the Senate shall designate a member of the Senate appointed
1045 under Subsection (1)(a) as a cochair of the committee.
1046 (b) The speaker of the House of Representatives shall designate a member of the House
1047 of Representatives appointed under Subsection (1)(b) as a cochair of the committee.
1048 (3) In conducting its business, the committee shall comply with the rules of legislative

1049 interim committees.
1050 (4) Salaries and expenses of the members of the committee shall be paid in accordance
1051 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
1052 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
1053 Sessions.
1054 (5) The Office of Legislative Research and General Counsel shall provide staff support
1055 to the committee.
1056 Section 17. **Duties -- Interim report.**
1057 (1) The committee shall review and make recommendations on the following issues:
1058 (a) the state's response to federal health care reform;
1059 (b) health coverage for children in the state;
1060 (c) the role and regulation of navigators assisting individuals with the selection and
1061 purchase of health benefit plans;
1062 (d) health insurance plans available on the Utah Health Exchange, including dental and
1063 vision plans and whether dental and vision plans can be included on the exchange in 2013;
1064 (e) the governance structure of the Utah Health Exchange, including advisory boards
1065 for the Utah Health Exchange or any other health exchange developed in the state;
1066 (f) no later than September 1, 2012, a recommendation to the Insurance Commissioner
1067 regarding a benchmark plan for the essential health benefit plan in the individual and small
1068 employer group market in the state;
1069 (g) the role of the state's high risk pool as a provider of a high risk product and its role
1070 in the establishment of a transitional reinsurance program;
1071 (h) the risk adjustment mechanism for the health exchange and methods to develop and
1072 administer a risk adjustment system that limits the administrative burden on government and
1073 health insurance plans, and creates stability in the insurance market;
1074 (i) whether the state should consider developing and offering a basic health plan in
1075 2014 to provide coverage options for individuals from 133% to 200% of the federal poverty
1076 level;
1077 (j) strategies to manage Medicaid expansion in 2014, including whether the Medicaid
1078 benefit plan should be the same as, or different from, the essential health benefit plan in the
1079 private insurance market;

1080 (k) individuals with dual health insurance coverage and the impact on the market;
1081 (l) cost containment strategies for health care, including durable medical equipment
1082 and home health care cost containment strategies;
1083 (m) analysis of cost effective bariatric surgery coverage; and
1084 (n) Medicaid behavioral and mental health delivery and payment reform models,
1085 including:
1086 (i) identifying and eliminating barriers to the delivery of effective mental, behavioral,
1087 and physical health care delivery systems;
1088 (ii) the costs and financing of mental and behavioral health care, including current cost
1089 drivers, cost shifting, cost containment measures, and the roles of local government programs,
1090 state government programs, and federal government programs; and
1091 (iii) innovative service delivery models that facilitate access to quality, cost effective
1092 and coordinated mental, behavioral, and physical health care.
1093 (2) A final report, including any proposed legislation shall be presented to the Health
1094 and Human Services and Business and Labor Interim Committees before November 30, 2012.
1095 Section 18. **Appropriation.**
1096 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, the
1097 following sums of money are appropriated from resources not otherwise appropriated, or
1098 reduced from amounts previously appropriated, out of the funds or accounts indicated for the
1099 fiscal year beginning July 1, 2011 and ending June 30, 2012. These are additions to any
1100 amounts previously appropriated for fiscal year 2012.
1101 To Legislature - Senate
1102 From General Fund, One-time $15,000
1103 Schedule of Programs:
1104 Administration $15,000
1105 To Legislature - House of Representatives
1106 From General Fund, One-time $25,000
1107 Schedule of Programs:
1108 Administration $25,000
1109 Section 19. **Repeal date.**
1110 The Health System Reform Task Force is repealed December 31, 2012.