# HEALTH SYSTEM REFORM AMENDMENTS

2010 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: David Clark**

Senate Sponsor: Wayne L. Niederhauser

**LONG TITLE**

**General Description:**

This bill amends provisions related to health system reform for the insurance market, health care providers, the Health Code, and the Office of Consumer Health Services.

**Highlighted Provisions:**

This bill:

- provides access to the Department of Health's all payer database, for limited purposes, to the Insurance Department's health care delivery and health care payment reform demonstration project, and for the risk adjusting mechanism of the defined contribution insurance market;
- authorizes the all payer database to analyze the data it collects to provide consumer awareness of costs and transparency in the health care market including:
  - reports on geographic variances in medical costs; and
  - cost increases for health care;
- clarifies the restrictions and protections for identifiable health information;
- requires health care facilities to post prices for patients;
- consolidates statutory language requiring insurance department reports concerning the health insurance market;
- makes technical and clarifying amendments to the price and value comparison of health benefit plans;
- amends the amount of excess fees from the department that will be treated as free revenue;
- requires the insurance commissioner to convene a group to develop a method of

comparing health insurers' claims denial, and other information that would help a consumer compare the value of health plans, and requires an administrative rule to implement the transparency reports;

- instructs the Insurance Department to continue its work with the Office of Consumer Health Services and the Department of Health to develop additional demonstration projects for health care delivery and payment reform and to apply for available grants to implement and expand the demonstration projects;
- makes a technical amendment to the health plans an insurer may offer after July 1, 2012;
- requires the Insurance Department to:
  - convene a group to simplify the uniform health insurance application and decrease the number of questions; and
  - develop a uniform waiver of coverage form;
- amends group and blanket conversion coverage related to NetCare;
- creates ongoing monthly enrollment for employers in the defined contribution market and makes conforming amendments;
- allows a pilot program for a limited number of large employer groups to enter the defined contribution market by January 1, 2011;
- requires an insurer in the defined contribution market to offer a choice of health benefit plans that vary as follows:
  - the basic benefit plan;
  - one plan that has an actuarial value that is at least 15% higher than the actuarial value of the basic benefit plan;
  - one plan that is a federally qualified high deductible plan that has the highest deductible that qualifies as a federally qualified high deductible plan;
  - one plan that is a federally qualified high deductible plan with an individual deductible of $2,500 and a deductible of $5,000 for two or more people; and
  - the carrier's five most popular health benefit plans;

- allows an insurer in the defined contribution market to offer:
  - any other health benefit plan that has a greater actuarial value than the actuarial value of the basic benefit plan; and
  - any other health benefit plan that has an actuarial value that is no lower than the actuarial value of the $2,500 federally qualified high deductible plan;
- gives carriers the option to participate in the defined contribution market on the Health Insurance Exchange by offering defined contribution products or defined benefit products on the exchange;
- provides that a carrier that does not choose to participate in the Health Insurance Exchange by January 1, 2011, may not participate in the exchange until January 1, 2013;
- allows small employers the choice of selecting insurance products in the Health Insurance Exchange or in the traditional market outside of the exchange;
- permits a carrier to offer defined benefit products in the traditional market outside of the Health Insurance Exchange if the carrier uses the same rating and underwriting practices in the defined benefit market and the Health Insurance Exchange so that rating practices do not favor one market over the other market;
- prohibits insurers in the defined contribution market from treating renewing groups as new business, subject to premium rate increases, based on the employer's move from the traditional market into a defined benefit or defined contribution plan in the Health Insurance Exchange;
- creates a procedure for a producer to be appointed as a producer for the defined contribution market;
- requires an insurer to obtain the Insurance Department's approval to use a class of businesses for underwriting purposes;
- effective January 1, 2011, modifies underwriting and rating practices in the small group market, in and out of the Health Insurance Exchange by:
  - standardizing age bands and slopes;

- standardizing family tiers;
- removing gender from case characteristics;
- removing group size and industry classification from case characteristics;

▸ makes amendments to the defined contribution risk adjuster to incorporate large groups into the risk adjuster;

▸ effective January 1, 2013, imposes a risk adjuster mechanism on the small group market inside and outside of the Health Insurance Exchange;

▸ requires health care providers to give consumers information about prices;

▸ requires the Health Insurance Exchange to:

- create an advisory board of appointed producers and consumers;
- establish the electronic standards for delivering the uniform health insurance application; and
- appoint an independent actuary to monitor the risk and underwriting practices of small employer group carriers to ensure that the carriers are using the same rating practices inside the Health Insurance Exchange and in the traditional insurance market;

▸ clarifies the type of information that an insurer must submit to the Health Insurance Exchange and to the Insurance Department; and

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

**Monies Appropriated in this Bill:**

None

**Other Special Clauses:**

This bill provides an effective date.

**Utah Code Sections Affected:**

AMENDS:

**26-1-37**, as enacted by Laws of Utah 2008, Chapter 379

**26-33a-106.1**, as enacted by Laws of Utah 2007, Chapter 29

**26-33a-109**, as enacted by Laws of Utah 1990, Chapter 305

**31A-2-201**, as last amended by Laws of Utah 2008, Chapter 382

**31A-3-304 (Effective 07/01/10)**, as last amended by Laws of Utah 2009, Chapter 183

**31A-22-613.5**, as last amended by Laws of Utah 2009, Chapter 12

**31A-22-614.6**, as enacted by Laws of Utah 2009, Chapter 11

**31A-22-618.5**, as enacted by Laws of Utah 2009, Chapter 12

**31A-22-625**, as last amended by Laws of Utah 2008, Chapters 345 and 382

**31A-22-635**, as enacted by Laws of Utah 2008, Chapter 383

**31A-22-723**, as last amended by Laws of Utah 2009, Chapter 12

**31A-30-103**, as last amended by Laws of Utah 2009, Chapter 12

**31A-30-105**, as last amended by Laws of Utah 1995, Chapter 321

**31A-30-106**, as last amended by Laws of Utah 2008, Chapters 382, 383, and 385

**31A-30-106.5**, as last amended by Laws of Utah 2001, Chapter 116

**31A-30-202**, as enacted by Laws of Utah 2009, Chapter 12

**31A-30-203**, as enacted by Laws of Utah 2009, Chapter 12

**31A-30-204**, as enacted by Laws of Utah 2009, Chapter 12

**31A-30-205**, as enacted by Laws of Utah 2009, Chapter 12

**31A-30-207**, as enacted by Laws of Utah 2009, Chapter 12

**31A-42-102**, as enacted by Laws of Utah 2009, Chapter 12

**31A-42-103**, as enacted by Laws of Utah 2009, Chapter 12

**31A-42-201**, as enacted by Laws of Utah 2009, Chapter 12

**31A-42-202**, as enacted by Laws of Utah 2009, Chapter 12

**63I-1-231**, as renumbered and amended by Laws of Utah 2008, Chapter 382

**63I-2-231**, as last amended by Laws of Utah 2009, Chapter 11

**63M-1-2504**, as last amended by Laws of Utah 2009, Chapter 12

**63M-1-2506**, as enacted by Laws of Utah 2009, Chapter 12

ENACTS:

**26-21-26**, Utah Code Annotated 1953

**31A-2-201.2**, Utah Code Annotated 1953

**31A-30-106.1**, Utah Code Annotated 1953
**31A-30-202.5**, Utah Code Annotated 1953
**31A-30-209**, Utah Code Annotated 1953
**31A-42a-101**, Utah Code Annotated 1953
**31A-42a-102**, Utah Code Annotated 1953
**31A-42a-103**, Utah Code Annotated 1953
**31A-42a-201**, Utah Code Annotated 1953
**31A-42a-202**, Utah Code Annotated 1953
**31A-42a-203**, Utah Code Annotated 1953
**31A-42a-204**, Utah Code Annotated 1953
**58-5a-307**, Utah Code Annotated 1953
**58-31b-802**, Utah Code Annotated 1953
**58-67-804**, Utah Code Annotated 1953
**58-68-804**, Utah Code Annotated 1953
**58-69-806**, Utah Code Annotated 1953
**58-73-603**, Utah Code Annotated 1953

REPEALS AND REENACTS:

**31A-30-208**, as enacted by Laws of Utah 2009, Chapter 12

**Uncodified Material Affected:**

ENACTS UNCODIFIED MATERIAL

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

Section 1. Section **26-1-37** is amended to read:

**26-1-37. Duty to establish standards for the electronic exchange of clinical health information.**

(1) For purposes of this section:

(a) "Affiliate" means an organization that directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with another

organization.

(b) "Clinical health information" shall be defined by the department by administrative rule adopted in accordance with Subsection (2).

(c) "Electronic exchange":

(i) includes:

(A) the electronic transmission of clinical health data via Internet or extranet; and

(B) physically moving clinical health information from one location to another using magnetic tape, disk, or compact disc media; and

(ii) does not include exchange of information by telephone or fax.

(d) "Health care provider" means a licensing classification that is either:

(i) licensed under Title 58, Occupations and Professions, to provide health care; or

(ii) licensed under Chapter 21, Health Care Facility Licensing and Inspection Act.

(e) "Health care system" shall include:

(i) affiliated health care providers;

(ii) affiliated third party payers; and

(iii) other arrangement between organizations or providers as described by the department by administrative rule.

(f) "Qualified network" means an entity that:

(i) is a non-profit organization;

(ii) is accredited by the Electronic Healthcare Network Accreditation Commission, or another national accrediting organization recognized by the department; and

(iii) performs the electronic exchange of clinical health information among multiple health care providers not under common control, multiple third party payers not under common control, the department, and local health departments.

[~~(f)~~] (g) "Third party payer" means:

(i) all insurers offering health insurance who are subject to Section 31A-22-614.5; and

(ii) the state Medicaid program.

(2) (a) In addition to the duties listed in Section 26-1-30, the department shall, in

accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(i) define:

(A) "clinical health information" subject to this section; and

(B) "health system arrangements between providers or organizations" as described in Subsection (1)(e)(iii); and

(ii) adopt standards for the electronic exchange of clinical health information between health care providers and third party payers that are [~~in compliance with~~] for treatment, payment, health care operations, or public health reporting, as provided for in 45 C.F.R. Parts 160, 162, and 164, Health Insurance Reform: Security Standards.

(b) The department shall coordinate its rule making authority under the provisions of this section with the rule making authority of the Insurance Department under Section 31A-22-614.5. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Insurance Department is given the opportunity to comment on proposed rules.

(3) (a) Except as provided in Subsection (3)[~~(b)~~](e), a health care provider or third party payer in Utah is required to use the standards adopted by the department under the provisions of Subsection (2) if the health care provider or third party payer elects to engage in an electronic exchange of clinical health information with another health care provider or third party payer.

(b) A health care provider or third party payer may disclose information to the department or a local health department, by electronic exchange of clinical health information, as permitted by Subsection 45 C.F.R. 164.512(b).

(c) When functioning in its capacity as a health care provider or payer, the department or a local health department may disclose clinical health information by electronic exchange to another health care provider or third party payer.

(d) An electronic exchange of clinical health information by a health care provider, a third party payer, the department, or a local health department is a disclosure for treatment, payment, or health care operations if it complies with Subsection (3)(a) or (c) and is for

treatment, payment, or health care operations, as those terms are defined in 45 C.F.R. Parts 160, 162, and 164.

[~~(b)~~] (e) A health care provider or third party payer is not required to use the standards adopted by the department under the provisions of Subsection (2) if the health care provider or third party payer engage in the electronic exchange of clinical health information within a particular health care system.

(4) Nothing in this section shall limit the number of networks eligible to engage in the electronic data interchange of clinical health information using the standards adopted by the department under Subsection (2)(a)(ii).

(5) The department, a local health department, a health care provider, a third party payer, or a qualified network is not subject to civil liability for a disclosure of clinical health information if the disclosure is in accordance both with Subsection (3)(a) and with Subsection (3)(b), 3(c), or 3(d).

(6) Within a qualified network, information generated or disclosed in the electronic exchange of clinical health information is not subject to discovery, use, or receipt in evidence in any legal proceeding of any kind or character.

[~~(5)~~] (7) The department shall report on the use of the standards for the electronic exchange of clinical health information to the legislative Health and Human Services Interim Committee no later than October 15[~~, 2008 and no later than every October 15th thereafter~~] of each year. The report shall include publicly available information concerning the costs and savings for the department, third party payers, and health care providers associated with the standards for the electronic exchange of clinical health records.

Section 2. Section **26-21-26** is enacted to read:

**26-21-26. Consumer access to health care facility charges.**

Beginning January 1, 2011, a health care facility licensed under this chapter shall, when requested by a consumer:

(1) make a list of prices charged by the facility available for the consumer that includes the facility's:

(a) in-patient procedures;

(b) out-patient procedures;

(c) the 50 most commonly prescribed drugs in the facility;

(d) imaging services; and

(e) implants; and

(2) provide the consumer with information regarding any discounts the facility provides for:

(a) charges for services not covered by insurance; or

(b) prompt payment of billed charges.

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 [~~from the Utah Health Insurance Association~~] 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) share data regarding insurance claims 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 in the defined contribution arrangement market; and

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

(iv) 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-109** is amended to read:

**26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.**

(1) The committee may not disclose any identifiable health data unless:

[~~(1)~~] (a) the individual has [~~consented to~~] authorized the disclosure; or

[~~(2)~~] (b) the disclosure [~~is to any organization that has an institutional review board,~~] complies with the provisions of this section.

(2) The committee shall consider the following when responding to a request for disclosure of information that may include identifiable health data:

(a) whether the request comes from a person after that person has received approval to do the specific research and statistical work from an institutional review board; and

(b) whether the requesting entity complies with the provisions of Subsection (3).

(3) A request for disclosure of information that may include identifiable health data shall:

(a) be for a specified period[~~,~~]; or

(b) be solely for bona fide research and statistical purposes[;] as determined in accordance with administrative rules adopted by the department [~~rules, and~~], which shall require:

(i) the requesting entity to demonstrate to the department [~~determines~~] that the data is required for the research and statistical purposes proposed by the requesting entity; and

(ii) the requesting [~~individual or organization enters~~] entity to enter into a written agreement satisfactory to the department to protect the data in accordance with this chapter or

other applicable law [~~and not permit further disclosure~~].

(4) A person accessing identifiable health data pursuant to Subsection (3) may not further disclose the identifiable health data:

(a) without prior approval of the department[~~. Any~~]; and

(b) unless the identifiable health data is disclosed [~~shall be~~] or identified by control number only.

Section 5. Section **31A-2-201** is amended to read:

**31A-2-201. General duties and powers.**

(1) The commissioner shall administer and enforce this title.

(2) The commissioner has all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to perform the duties imposed by this title.

(3) (a) The commissioner may make rules to implement the provisions of this title according to the procedures and requirements of Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) In addition to the notice requirements of Section 63G-3-301, the commissioner shall provide notice under Section 31A-2-303 of hearings concerning insurance department rules.

(4) (a) The commissioner shall issue prohibitory, mandatory, and other orders as necessary to secure compliance with this title. An order by the commissioner is not effective unless the order:

(i) is in writing; and

(ii) is signed by the commissioner or under the commissioner's authority.

(b) On request of any person who would be affected by an order under Subsection (4)(a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

(5) (a) The commissioner may hold informal adjudicative proceedings and public meetings, for the purpose of:

(i) investigation;

(ii) ascertainment of public sentiment; or

(iii) informing the public.

(b) An effective rule or order may not result from informal hearings and meetings unless the requirement of a hearing under this section is satisfied.

(6) The commissioner shall inquire into violations of this title and may conduct any examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, that the commissioner considers proper to determine:

(a) whether or not any person has violated any provision of this title; or

(b) to secure information useful in the lawful administration of this title.

[~~(7) (a) Each year, the commissioner shall:~~]

[~~(i) conduct an evaluation of the state's health insurance market;~~]

[~~(ii) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1; and~~]

[~~(iii) publish the findings of the evaluation on the department website.~~]

[~~(b) The evaluation required by Subsection (7)(a) shall:~~]

[~~(i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as:~~]

[~~(A) the availability and marketing of individual and group products;~~]

[~~(B) rate charges;~~]

[~~(C) coverage and demographic changes;~~]

[~~(D) benefit trends;~~]

[~~(E) market share changes; and~~]

[~~(F) accessibility;~~]

[~~(ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;~~]

[~~(iii) contain recommendations for action to improve the overall effectiveness of the~~

~~health insurance market, administrative rules, and statutes; and~~]

[~~(iv) include claims loss ratio data for each insurance company doing business in the state.~~]

[~~(c) When preparing the evaluation required by this Subsection (7), the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.~~]

Section 6. Section **31A-2-201.2** is enacted to read:

**31A-2-201.2. Evaluation of Health Insurance Market.**

(1) Each year the commissioner shall:

(a) conduct an evaluation of the state's health insurance market;

(b) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1 of each year; and

(c) publish the findings of the evaluation on the department website.

(2) The evaluation required by this section shall:

(a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:

(i) the availability and marketing of individual and group products;

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

(b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;

(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and

(d) include claims loss ratio data for each health insurance company doing business in the state.

(3) When preparing the evaluation required by this section, the commissioner shall include a report of:

(a) the types of health benefit plans sold in the Health Insurance Exchange created in Section 63M-1-2504;

(b) the number of insurers participating in the defined contribution arrangement health benefit plans in the Health Insurance Exchange;

(c) the number of employers and covered lives in the defined contribution arrangement market in the Health Insurance Exchange; and

(d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).

(4) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(5) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(6) 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 7. Section **31A-3-304 (Effective 07/01/10)** is amended to read:

**31A-3-304 (Effective 07/01/10). Annual fees -- Other taxes or fees prohibited.**

(1) (a) A captive insurance company shall pay an annual fee imposed under this section to obtain or renew a certificate of authority.

(b) The commissioner shall:

(i) determine the annual fee pursuant to Sections 31A-3-103 and 63J-1-504; and

(ii) consider whether the annual fee is competitive with fees imposed by other states on captive insurance companies.

(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.

(3) (a) Except as provided in Subsection (3)(b) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the fee provided for in this section constitutes the sole tax or fee under the laws of this state that may be otherwise levied or assessed on a captive insurance company, and no other occupation tax or other tax or fee may be levied or collected from a captive insurance company by the state or a county, city, or municipality within this state.

(b) Notwithstanding Subsection (3)(a), a captive insurance company is subject to real and personal property taxes.

(4) A captive insurance company shall pay the fee imposed by this section to the department by March 31 of each year.

(5) (a) The funds received pursuant to Subsection (2) shall be deposited into the General Fund as a dedicated credit to be used by the department to:

(i) administer and enforce Chapter 37, Captive Insurance Companies Act; and

(ii) promote the captive insurance industry in Utah.

(b) At the end of each fiscal year, funds received by the department in excess of [~~$750,000~~] $600,000 shall be treated as free revenue in the General Fund.

Section 8. Section **31A-22-613.5** is amended to read:

**31A-22-613.5. Price and value comparisons of health insurance -- Basic Health Benefit Plan.**

(1) (a) [~~Except as provided in Subsection (1)(b), this~~] This section applies to all health [~~insurance policies and health maintenance organization contracts~~] benefit plans.

(b) Subsection (2) applies to:

(i) all [~~health insurance policies and health maintenance organization contracts~~] 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 insurance and~~] health benefit plans by requiring an insurer issuing [~~health insurance~~

~~policies or health maintenance organization contracts~~] a health benefit plan to:

(i) provide to all enrollees, prior to enrollment in the health benefit plan [~~or health insurance policy,~~] written disclosure of:

[~~(i)~~] (A) restrictions or limitations on prescription drugs and biologics including:

(I) the use of a formulary [~~and~~];

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

(III) requirements for generic substitution;

[~~(ii)~~] (B) coverage limits under the plan; and

[~~(iii)~~] (C) any limitation or exclusion of coverage including:

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

[~~(B)~~] (II) [~~beginning July 1, 2009,~~] 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 63M-1-2506(3) through (6) in the standardized electronic format required by Subsection 63M-1-2506(1); and

(B) information regarding insurer transparency in accordance with Subsection (5).

(b) [~~In addition to the requirements of Subsections (2)(a), (d), and (e) an insurer described in Subsection (2)(a)~~] An insurer shall [~~file~~] provide the [~~written~~] disclosure required by [~~this~~] Subsection (2)(a)(i) [~~to the commissioner~~]:

(i) in writing to the commissioner;

[~~(i)~~] (A) upon commencement of operations in the state; and

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

[~~(A)~~] (I) treatment policies;

[~~(B)~~] (II) practice standards;

[~~(C)~~] (III) restrictions;

[~~(D)~~] (IV) coverage limits of the insurer's health benefit plan or health insurance

policy; or

[~~(E)~~] (V) 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[~~.~~]; and

(ii) to the enrollee, notice of the change in prescription drug coverage under Subsection (2)(a)(i)(A):

(A) either in writing or through the insurer's website; and

(B) at least 30 days prior to the date of the implementation of the change in prescription drug coverage, or as soon as reasonably possible.

[~~(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (2), taking into account:~~]

[~~(i) business confidentiality of the insurer;~~]

[~~(ii) definitions of terms;~~]

[~~(iii) the method of disclosure to enrollees; and~~]

[~~(iv) limitations and exclusions.~~]

[~~(d)~~] (c) 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)~~] (d) (i) The department shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(a)[~~(iii)~~](i)(C).

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)[~~(iii)~~](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) An insurer who offers a health [~~care~~] benefit plan under Chapter 30, Individual, Small Employer, and Group Health Insurance Act, shall[~~: (a) until January 1, 2010, offer the basic health care plan described in Subsection (4) subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and (b) beginning January 1, 2010,~~] offer a basic health care plan subject to the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act, that:

[~~(i)~~] (a) is a federally qualified high deductible health plan;

[~~(ii)~~] (b) has the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and

[~~(iii)~~] (c) does not exceed an annual out of pocket maximum equal to three times the amount of the annual deductible.

[~~(4) Until January 1, 2010, the Basic Health Care Plan under this section shall provide for:~~]

[~~(a) a lifetime maximum benefit per person not less than $1,000,000;~~]

[~~(b) an annual maximum benefit per person not less than $250,000;~~]

[~~(c) an out-of-pocket maximum of cost-sharing features:~~]

[~~(i) including:~~]

[~~(A) a deductible;~~]

[~~(B) a copayment; and~~]

[~~(C) coinsurance;~~]

[~~(ii) not to exceed $5,000 per person; and~~]

[~~(iii) for family coverage, not to exceed three times the per person out-of-pocket maximum provided in Subsection (4)(c)(ii);~~]

[~~(d) in relation to its cost-sharing features:~~]

[~~(i) a deductible of:~~]

[~~(A) not less than $1,000 per person for major medical expenses; and~~]

[~~(B) for family coverage, not to exceed three times the per person deductible for major medical expenses under Subsection (4)(d)(i)(A); and~~]

[~~(ii) (A) a copayment of not less than:~~]

[~~(I) $25 per visit for office services; and~~]

[~~(II) $150 per visit to an emergency room; or~~]

[~~(B) coinsurance of not less than:~~]

[~~(I) 20% per visit for office services; and~~]

[~~(II) 20% per visit for an emergency room; and~~]

[~~(c) in relation to cost-sharing features for prescription drugs:~~]

[~~(i) (A) a deductible not to exceed $1,000 per person; and~~]

[~~(B) for family coverage, not to exceed three times the per person deductible provided in Subsection (4)(c)(i)(A); and~~]

[~~(ii) (A) a copayment of not less than:~~]

[~~(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;~~]

[~~(II) the lesser of the cost of the prescription drug or $25 for the second level of cost for prescription drugs; and~~]

[~~(III) the lesser of the cost of the prescription drug or $35 for the highest level of cost for prescription drugs; or~~]

[~~(B) coinsurance of not less than:~~]

[~~(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription drugs;~~]

[~~(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and~~]

[~~(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.~~]

[~~(5) The department shall include in its yearly insurance market report information about:~~]

[~~(a) the types of health benefit plans sold on the Internet portal created in Section 63M-1-2504;~~]

[~~(b) the number of insurers participating in the defined contribution market on the Internet portal;~~]

[~~(c) the number of employers and covered lives in the defined contribution market; and~~]

[~~(d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).~~]

[~~(6)~~] (4) 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 [~~to the Internet portal under Subsection 63M-1-2506(4)~~] under this section.

(5) 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), 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 must submit to the department 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 must submit the data to the department in order for the department to transmit the data to the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(c) implement the rules adopted under Subsection (5)(b) in a manner that protects the business confidentiality of the insurer.

Section 9. Section **31A-22-614.6** is amended to read:

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

(1) The Legislature finds that:

(a) current health care delivery and payment systems do not provide systemwide aligned incentives for the appropriate delivery of health care;

(b) some health care providers and health care payers have developed ideas for health care delivery and payment system reform, but lack the critical number of patient lives and payer involvement to accomplish systemwide reform; and

(c) there is a compelling state interest to encourage as many health care providers and health care payers to join together and coordinate efforts at systemwide health care delivery and payment reform.

(2) (a) The Office of Consumer Health Services within the Governor's Office of Economic Development shall convene meetings of health care providers and health care payers through a neutral, non-biased entity that can demonstrate it has the support of a broad base of the participants in this process for the purpose of coordinating broad based demonstration projects for health care delivery and payment reform.

(b) (i) The speaker of the House of Representatives may appoint a person who is a member of the House of Representatives, or from the Office of Legislative Research and General Counsel, to attend the meetings convened under Subsection (2)(a).

(ii) The president of the Senate may appoint a person who is a senator, or from the Office of Legislative Research and General Counsel, to attend the meetings convened under

Subsection (2)(a).

(c) Participation in the coordination efforts by health care providers and health care payers is voluntary, but is encouraged.

(3) The commissioner and the Office of Consumer Health Services shall facilitate several coordinated broad based demonstration projects for health care delivery reform and health care payment reform between [~~various~~] one or more health care providers and one or more health care payers who elect to participate in the demonstration projects by:

(a) consulting with health care providers and health care payers who elect to join together in a broad based reform demonstration project; [~~and~~]

(b) consulting with a neutral, non-biased third party with an established record for broad based, multi-payer and multi-provider quality assurance efforts and data collection;

(c) applying for grants and assistance that may be available for creating and implementing the demonstration projects; and

[~~(b)~~] (d) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to develop, oversee, and implement the demonstration [~~project~~] projects.

(4) The Office of Consumer Health Services and the commissioner shall report to the Health System Reform Task Force by October [~~2009~~] 2010, and to the Legislature's Business and Labor Interim Committee every October thereafter regarding the progress towards coordination of broad based health care system payment and delivery reform.

Section 10. Section **31A-22-618.5** is amended to read:

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

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

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

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

and

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

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

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

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

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

(D) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

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

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

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

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

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

(i) tier one contracted providers;

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

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

(b) notwithstanding Subsection 31A-22-617(9) may offer a health benefit plan that is not subject to [~~Subsection 31A-22-617(9) and~~] Section 31A-22-618;

(c) beginning July 1, 2012, may offer products under Subsection (3)(a) that:

(i) are not subject to Subsection 31A-22-617(2); and

(ii) are subject to the reimbursement requirements in Section 31A-8-501;

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

(e) are not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

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

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

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

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

Section 11. Section **31A-22-625** is amended to read:

**31A-22-625. Catastrophic coverage of mental health conditions.**

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan or health maintenance organization contract that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing

factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health benefit plan or health maintenance organization contract that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on episodic limits, inpatient or outpatient service limits, or maximum out-of-pocket limits.

(c) "Large employer" is as defined in Section 31A-1-301.

(d) (i) "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) marital or family problem;

(B) social, occupational, religious, or other social maladjustment;

(C) conduct disorder;

(D) chronic adjustment disorder;

(E) psychosexual disorder;

(F) chronic organic brain syndrome;

(G) personality disorder;

(H) specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in Section 31A-1-301.

(2) (a) At the time of purchase and renewal, an insurer shall offer to each small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.

(b) In addition to Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, choose either catastrophic mental health coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the employer's previous coverage for mental health conditions.

(d) An insurer is exempt from the 30% index rating restriction in [~~Subsection 31A-30-106(1)(b)~~] Section 31A-30-106.1 and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in [~~Subsection 31A-30-106(1)(c)(ii)~~] Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) (a) At the time of purchase and renewal of a health benefit plan, an insurer shall offer catastrophic mental health coverage to each large employer that it insures or seeks to insure.

(b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental health coverage at levels that exceed the minimum requirements of this section.

(c) A large employer may, at its option, choose either catastrophic mental health coverage, coverage that excludes benefits for mental health conditions, or coverage offered under Subsection (3)(b).

(4) (a) An insurer may provide catastrophic mental health coverage through a managed care organization or system in a manner consistent with the provisions in Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide any benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility licensed or otherwise authorized to provide mental health services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may prohibit a policy or contract that provides mental health coverage in a manner that is inconsistent with this section.

(6) The commissioner shall:

(a) adopt rules as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of contracts and policies that include no mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and coverage that exceeds the minimum requirements of this section.

(7) The Health and Human Services Interim Committee shall review:

(a) the impact of this section on insurers, employers, providers, and consumers of mental health services before January 1, 2004; and

(b) make a recommendation as to whether the provisions of this section should be modified and whether the cost-sharing requirements for mental health conditions should be the same as for physical health conditions.

(8) (a) An insurer shall offer catastrophic mental health coverage as part of a health maintenance organization contract that is governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.

(b) An insurer shall offer catastrophic mental health coverage as a part of a health benefit plan that is not governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after July 1, 2001.

(c) This section does not apply to the purchase or renewal of an individual insurance policy or contract.

(d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as discouraging or otherwise preventing insurers from continuing to provide mental health coverage in connection with an individual policy or contract.

(9) This section shall be repealed in accordance with Section 63I-1-231.

Section 12. Section **31A-22-635** is amended to read:

**31A-22-635. Development of uniform health insurance application -- Uniform waiver of coverage.**

(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) [~~Beginning July 1, 2009, all insurers~~] Insurers offering [~~health insurance~~] a health benefit plan to an individual or small employer shall:

(i) except as provided in Subsection (6), use a uniform application form[~~.~~], which, beginning October 1, 2010:

(A) except for cancer and transplants, may not include questions about an applicant's health history prior to the previous 10 years; and

(B) shall be shortened and simplified in accordance with rules adopted by the department; and

(ii) use a uniform waiver of coverage form, which:

(A) may not include health status related questions other than pregnancy; and

(B) 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.

(b) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may be combined or modified to facilitate:

(i) the electronic submission and processing of an application through the Health Insurance Exchange created pursuant to Section 63M-1-2504 or directly to all carriers; and

(ii) a more efficient and understandable experience for a consumer submitting an application in the Health Insurance Exchange or directly to all carriers.

(3) An insurer offering a defined contribution arrangement health benefit plan in the Health Insurance Exchange to a large group shall use a large group uniform application, and uniform waiver of coverage form, that is adopted by the department by administrative rule.

[~~(3)~~] (4) (a) (i) 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.

(ii) Modifications to the uniform application necessary to facilitate the electronic submission and processing of an application through the Health Insurance Exchange shall be adopted by administrative rule adopted by the Office of Consumer Health Services in accordance with Section 63M-1-2506.

(b) The commissioner shall [~~consult with~~] convene the health insurance industry [~~when adopting the uniform application form~~], the Office of Consumer Health Services, and

consumers to review the uniform application for the individual and small group market, and the large group market, and make recommendations regarding the uniform applications. The department shall report the findings of the group convened pursuant to this Subsection (4)(b) to the Legislature no later than July 1, 2010.

[~~(4)~~] (5) (a) Beginning [~~July 1, 2010, all insurers~~] October 1, 2010, an insurer who offers a health benefit plan on the Health Insurance Exchange created in Section 63M-1-2504, shall [~~offer compatible systems of electronic submission of application forms, approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. The systems approved by the commissioner may include monitoring and disseminating information concerning eligibility and coverage of individuals.~~]:

(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; and

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

(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.

(6) An insurer offering a health benefit plan outside the Health Insurance Exchange may use the uniform application in effect prior to May 15, 2010, until January 1, 2011.

Section 13. Section **31A-22-723** is amended to read:

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

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

(2) A person who has lost group coverage may elect conversion coverage with the

insurer that provided prior group coverage if the person:

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

(b) has exhausted either:

(i) Utah mini-COBRA coverage as required in Section 31A-22-722;

(ii) federal COBRA coverage; or

(iii) alternative coverage under Section 31A-22-724;

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

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

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

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

(i) catastrophic benefits;

(ii) aggregate stop loss benefits;

(iii) specific stop loss benefits;

(iv) benefits for specific diseases;

(v) accidental injuries only;

(vi) dental; or

(vii) vision;

(b) is an income replacement policy;

(c) was terminated because the insured:

(i) failed to pay any required individual contribution;

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

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

(d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or 31A-30-107(2)(a).

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

(i) the terminated insured;

(ii) the ex-spouse; or

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

(A) the surviving spouse; and

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

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

(i) be sent by first class mail;

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

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

(A) the insured;

(B) the ex-spouse; and

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

(I) the surviving spouse; and

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

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

(b) Except as provided in Subsection (5)(c), if the conversion is made from a health benefit plan, the employee or member shall be offered:

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

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

(c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are

substantially similar to those provided under the group policy.

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

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

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

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

(c) The premium for converted policies shall be payable monthly or quarterly as required by the insurer for the policy form and plan selected, unless another mode or premium payment is mutually agreed upon.

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

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

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

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

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

(i) the insured;

(ii) a spouse of the insured; or

(iii) a dependent of the insured.

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

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

(a) a dependent is no longer eligible under the policy;

(b) for a network plan, if the individual no longer lives, resides, or works in:

(i) the insured's service area; or

(ii) the area for which the covered carrier is authorized to do business;

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

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

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

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

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

(14) An insurer is only required to offer a conversion policy that complies with Subsection 31A-22-724(1)(b) and, notwithstanding Sections 31A-8-402.5 and 31A-30-107.1, may discontinue any other conversion policy if:

(a) the discontinued conversion policy is discontinued uniformly without regard to any health related factor;

(b) any affected individual is provided with 90 days' advanced written notice of the discontinuation of the existing conversion policy;

(c) the policy holder is offered the insurer's conversion policy that complies with Subsection 31A-22-724(1)(b); and

(d) the policy holder is not re-rated for purposes of premium calculation.

Section 14. Section **31A-30-103** is amended to read:

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

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic benefit plan" or "basic coverage" means the coverage provided in the Basic Health Care Plan under Section 31A-22-613.5.

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

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

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

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means

demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

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

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds [~~established under~~] that is permitted by the department in accordance with Section 31A-30-105.

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

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

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

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

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

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

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

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

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

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

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

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

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

(a) an individual; or

(b) an individual with a family.

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

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

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

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

[~~(a) the deductible or limit year used under the plan;~~]

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

[~~(c) if the plan does not impose a deductible or limit on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer's taxable year; or~~]

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

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

[~~(22)~~] (20) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

[~~(23)~~] (21) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

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

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

[~~(24)~~] (22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

[~~(25)~~] (23) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

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

[~~(26)~~] (24) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

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

[~~(27)~~] (25) "Uninsurable" means an individual who:

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

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

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

[~~(28)~~] (26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

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

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

Section 15. Section **31A-30-105** is amended to read:

**31A-30-105. Establishment of classes of business.**

(1) [~~A~~] For policies that go into effect on or after January 1, 2011, a covered carrier may not establish a separate class of business [~~only to reflect~~] unless:

(a) the covered carrier submits an application to the department to establish a separate class of business;

(b) the covered carrier demonstrates to the satisfaction of the department that a separate class of business is justified under the provisions of this section; and

(c) the department approves the carrier's application for the use of a separate class of business.

(2) (a) The presumption of the department shall be against the use of a separate class of business by a covered insured, except when the covered carrier demonstrates that the provisions of this Subsection (2) apply.

(b) The department may approve the use of a separate class of business only if the covered carrier can demonstrate that the use of a separate class of business is necessary due to substantial differences in either expected claims experience or administrative costs related to the following reasons:

[~~(a)~~] (i) the covered carrier uses more than one type of system for the marketing and sale of health benefit plans to covered insureds;

[~~(b)~~] (ii) the covered carrier has acquired a class of business from another covered carrier; or

[~~(c)~~] (iii) the covered carrier provides coverage to one or more association groups.

[~~(2) A covered carrier may establish up to nine separate classes of business under Subsection (1).~~]

(3) The commissioner may establish regulations to provide for a period of transition in order for a covered carrier to come into compliance with Subsection (2) in the instance of acquisition of an additional class of business from another covered carrier.

(4) The commissioner may approve the establishment of [~~additional~~] up to five classes of business per covered carrier upon application to the commissioner and a finding by the commissioner that such action would substantially enhance the efficiency and fairness of the health insurance marketplace subject to this chapter.

(5) A covered carrier may not establish a class of business based solely on the marketing or sale of a health benefit plan as a defined contribution arrangement health benefit plan, or through the Health Insurance Exchange.

Section 16. Section **31A-30-106** is amended to read:

**31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

(1) Premium rates for health benefit plans for individuals under this chapter are subject to the provisions of this [~~Subsection (1)~~] section.

(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) (i) 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 [~~such employers~~] the individual 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 as provided in Section 31A-22-625~~] provided in Section 31A-30-106.1.

(ii) A [~~covered~~] carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies,

even if some individual policies are rated below the small employer base rate.

(c) 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:

(i) 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;

(ii) 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 [~~covered carrier's~~] rate manual for the class of business[~~, except as provided in Section 31A-22-625~~] of the carrier offering an individual health benefit plan; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the [~~covered carrier's~~] rate manual for the class of business of the carrier offering an individual health benefit plan.

[~~(d) (i) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.~~]

[~~(ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the rates charged for all employees and dependents of the small employer.~~]

[~~(e) A covered carrier may use industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.~~]

[~~(f) (i) Covered carriers~~]

(d) (i) A carrier offering an individual health benefit plan shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical [~~groups~~] individuals that:

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

(B) do not reflect differences due to the nature of the [~~groups~~] individuals assumed to select particular health benefit products.

(iii) A [~~covered~~] carrier offering an individual health benefit plan shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

[~~(g)~~] (e) For the purposes of this Subsection (1), 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.

[~~(h) The covered carrier~~] (f) A carrier offering a health benefit plan to an individual may not, without prior approval of the commissioner, use case characteristics other than:

(i) age;

(ii) gender;

[~~(iii) industry;~~]

[~~(iv)~~] (iii) geographic area; and

[~~(v)~~] (iv) family composition[~~; and~~].

[~~(vi) group size.~~]

[~~(i)~~] (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(A) implement this chapter; and

(B) assure that rating practices used by [~~covered~~] carriers who offer health benefit plans to individuals are consistent with the purposes of this chapter.

(ii) The rules described in Subsection (1)[~~(i)~~](g)(i) may include rules that:

(A) assure that differences in rates charged for health benefit products by [~~covered~~] carriers who offer health benefit plans to individuals are reasonable and reflect objective differences in plan design, not including differences due to the nature of the [~~groups~~] individuals assumed to select particular health benefit products;

(B) prescribe the manner in which case characteristics may be used by [~~covered~~] carriers who offer health benefit plans to individuals;

(C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

(D) establish the individual enrollment cap under Subsection 31A-30-110(1).

[~~(j)~~] (h) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 325% of that expected for a standard insurable individual with the same case characteristics.

[~~(k)~~] (i) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered 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 covered carrier is actively enrolling new covered insureds.

(3) (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) [~~to~~] case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

[~~(4) (a) Each covered carrier~~]

(4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the [~~covered~~] 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 [~~covered~~] 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 [~~covered~~] carrier subject to this section shall file with the commissioner, on or before April 1 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the [~~covered~~] carrier is in compliance with this chapter; and

(B) the rating methods of the [~~covered~~] carrier are actuarially sound.

(ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the [~~covered~~] carrier at the [~~covered~~] carrier's principal place of business.

(c) A [~~covered~~] carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) 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 17. Section **31A-30-106.1** is enacted 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 the provisions of this section for a health benefit plan that is issued or renewed, on or after January 1, 2011.

(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 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, as determined at the beginning of the plan year, limited to:

(i) the following age bands:

(A) less than 20;

(B) 20-24;

(C) 25-29;

(D) 30-34;

(E) 35-39;

(F) 40-44;

(G) 45-49;

(H) 50-54;

(I) 55-59;

(J) 60-64; and

(K) 65 and above; and

(ii) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (6)(c):

(A) as developed by the department by administrative rule;

(B) not to exceed an overall ratio of 5:1; and

(C) the age slope ratios for each age band may not overlap;

(b) geographic area; and

(c) family composition, limited to:

(i) an overall ratio of 5:1 or less; and

(ii) a four tier rating structure that includes:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a dependent or dependents; and

(D) a family, consisting of an employee plus spouse, and a dependent or dependents.

(7) 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.

(8) (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.

(9) (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 (9)(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 (9) available to the commissioner upon request.

(10) (a) The commissioner shall, by July 1, 2010, 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, as effective on January 1, 2011, 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.

(11) 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 18. Section **31A-30-106.5** is amended to read:

**31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.**

(1) All provisions of Section [~~31A-30-106, except Subsection 31A-30-106(1)(b),~~] 31A-30-106.1 apply to conversion policies.

(2) Conversion policy premium rates may not exceed by more than 35% the index rate for [~~individuals~~] small employers with similar case characteristics for any class of business in

which the policy form has been approved.

(3) An insurer may not consider pregnancy of a covered insured in determining its conversion policy premium rates.

Section 19. Section **31A-30-202** is amended to read:

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

For purposes of this part:

(1) "Defined benefit plan" means an employer group health benefit plan in which:

(a) the employer selects the health benefit plan or plans from a single insurer;

(b) employees are not provided a choice of health benefit plans on the Health Insurance Exchange; and

(c) the employer is subject to contribution requirements in Section 31A-30-112.

[~~(1)~~] (2) "Defined contribution arrangement":

(a) means a defined contribution arrangement employer group health benefit plan that:

[~~(a)~~] (i) complies with this part; and

[~~(b)~~] (ii) is sold through the [~~Internet portal~~] Health Insurance Exchange in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act[~~.~~]; and

(b) beginning January 1, 2011, includes an employer choice of either a defined contribution arrangement health benefit plan or a defined benefit plan offered through the Health Insurance Exchange.

[~~(2)~~] (3) "Health reimbursement arrangement" means an employer provided health reimbursement arrangement in which reimbursements for medical care expenses are excluded from an employee's gross income under the Internal Revenue Code.

[~~(3)~~] (4) "Producer" is as defined in Subsection 31A-23a-501(4)(a).

[~~(4)~~] (5) "Section 125 Cafeteria plan" means a flexible spending arrangement that qualifies under Section 125, Internal Revenue Code, which permits an employee to contribute pre-tax dollars to a health benefit plan.

[~~(5)~~] (6) "Small employer" is defined in Section 31A-1-301.

Section 20. Section **31A-30-202.5** is enacted to read:

**31A-30-202.5. Insurer participation in defined contribution arrangement market.**

(1) A small employer carrier who chooses to participate in the defined contribution arrangement market:

(a) shall offer the defined contribution arrangement health benefit plans required by Section 31A-30-205;

(b) may:

(i) offer additional defined contribution arrangement health benefit plans in the Health Insurance Exchange as permitted by Section 31A-30-205;

(ii) offer a defined benefit plan in the Health Insurance Exchange if the small employer carrier offers a defined contribution arrangement health benefit plan that is actuarially equivalent to the defined benefit plan that is offered in the Health Insurance Exchange; and

(iii) continue to offer defined benefit plans outside of the Health Insurance Exchange and the defined contribution arrangement market, if the carrier uses the same rating and underwriting practices in both the defined contribution arrangement market in the Health Insurance Exchange and the defined benefit market outside the Health Insurance Exchange.

(2) A carrier that does not elect to participate in the defined contribution arrangement market by January 1, 2011, may not participate in the defined contribution arrangement market in the Health Insurance Exchange until January 1, 2013.

Section 21. Section **31A-30-203** is amended to read:

**31A-30-203. Eligibility for defined contribution arrangement market -- Enrollment.**

(1) (a) [~~Beginning January 1, 2010, and during the open enrollment period described in Section 31A-30-208, an~~] An eligible small employer may choose to [~~participate in~~] participate in:

(i) the defined contribution arrangement market in the Health Insurance Exchange under this part; or

(ii) the traditional defined benefit market under Part 1, Individual and Small Employer

Group.

(b) A small employer may choose to offer its employees one of the following through the defined contribution arrangement market in the Health Insurance Exchange:

(i) a defined contribution arrangement health benefit plan; or

(ii) a defined benefit plan.

(c) (i) Beginning January 1, 2011, and during the enrollment period, an eligible large employer participating in the demonstration project under Subsection 31A-30-208(1)(c) may choose to offer its employees a defined contribution arrangement health benefit plan.

[~~(b)~~] (ii) Beginning January 1, 2012, [~~and during the open enrollment period described in Section 31A-30-208,~~] an eligible large employer may choose to [~~participate in~~] offer its employees a defined contribution arrangement health benefit plan.

[~~(c)~~] (d) Defined contribution arrangement health benefit plans are employer group health plans individually selected by an employee of an employer.

(2) (a) Participating insurers[~~: (i)~~] shall offer to accept all eligible employees of an employer described in Subsection (1), and their dependents, at the same level of benefits as anyone else who has the same health benefit plan in the defined contribution arrangement market[~~; and~~] on the Health Insurance Exchange.

[~~(ii) may not impose a premium surcharge under Section 31A-30-106.7 in the defined contribution market.~~]

(b) A participating insurer may:

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

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

Section 22. Section **31A-30-204** is amended to read:

**31A-30-204. Employer election -- Defined benefit -- Defined contribution arrangements -- Responsibilities.**

(1) (a) An employer participating in the defined contribution arrangement market on the Health Insurance Exchange shall make an initial election to offer its employees either a defined benefit plan or a defined contribution arrangement health benefit plan.

(b) If an employer elects to offer a defined benefit plan:

(i) the employer or the employer's producer shall enroll the employer in the Health Insurance Exchange;

(ii) the employees shall submit the uniform application required for the Health Insurance Exchange; and

(iii) the employer shall select the defined benefit plan in accordance with Section 31A-30-208.

(c) When an employer makes an election under Subsections (1)(a) and (b):

(i) the employer may not offer its employees a defined contribution arrangement health benefit plan; and

(ii) the employees may not select a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

(d) If an employer elects to offer its employees a defined contribution arrangement health benefit plan, the employer shall comply with the provisions of Subsections (2) through (5).

[~~(1)~~] (2) (a) (i) An employer [~~described in Subsection 31A-30-203(1)~~] that chooses to participate in a defined contribution arrangement health benefit plan may not offer to an employee a [~~major medical~~] health benefit plan that is not a [~~part of the~~] defined contribution arrangement [~~to an employee~~] health benefit plan in the Health Insurance Exchange.

(ii) Subsection [~~(1)~~] (2)(a)(i) does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts for health care expenses.

(b) (i) To the extent permitted by Sections 31A-1-301, 31A-30-112, and 31A-30-206, and the risk adjustment plan adopted under Section [~~31A-42-202~~] 31A-42-204, the employer reserves the right to determine:

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

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

(ii) The determinations made under Subsection [~~(1)~~] (2)(b) may only be changed during periods of open enrollment.

[~~(2)~~] (3) An employer that chooses to establish a defined contribution arrangement health benefit plan to provide a health benefit plan for its employees shall:

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

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

(iii) another plan or arrangement similar to Subsection [~~(2)~~] (3)(a)(i) or (ii) which is excluded or deducted from gross income under the Internal Revenue Code;

(b) [~~by November 10 of the open enrollment period~~] before the employee's health benefit plan selection period:

(i) inform each employee of the health benefit plan the employer has selected as the default health benefit plan for the employer group;

(ii) offer each employee a choice of any of the defined contribution arrangement health benefit plans available through the defined contribution arrangement market on the [~~Internet portal~~] Health Insurance Exchange; and

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, [~~prior to November 25 of the open enrollment period~~] before the employee's selection period ends:

(A) [~~notifies the employer that the employee has selected~~] selects a different defined contribution arrangement health benefit plan available [~~through the defined contribution arrangement~~] in the [~~Internet portal~~] Health Insurance Exchange;

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

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

[~~(3)~~] (4) An employer shall enroll an employee in the default defined contribution arrangement health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection [~~(2)(b)(ii) prior to November 25 of the open enrollment period~~] (3)(b)(iii) before the end of the employee selection period, which may not be less than 14 calendar days.

[~~(4)~~] (5) The employer's notice to the employee under Subsection [~~(2)~~] (3)(b)(iii) shall inform the employee that the failure to act under Subsections [~~(2)~~] (3)(b)(iii)(A) through (C) is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

Section 23. Section **31A-30-205** is amended to read:

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

(1) An insurer who [~~chooses to offer a health benefit plan in the~~] offers a defined contribution [~~market must~~] arrangement health benefit plan shall offer the following health benefit plans as defined contribution arrangements:

[~~(a) one health benefit plan that:~~]

[~~(i) is a federally qualified high deductible health plan;~~]

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

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

(a) the basic benefit plan;

(b) one health benefit plan with [~~benefits that have~~] an aggregate actuarial value at least 15% greater [~~that~~] than the [~~plan described in Subsection (1)(a).~~] actuarial value of the basic benefit plan;

(c) one health benefit plan that is a federally qualified high deductible health plan that has an individual deductible of $2,500 and a deductible of $5,000 for coverage including two

or more individuals, and has an out of pocket maximum equal to the level of the deductible;

(d) one health benefit plan that is a federally qualified high deductible health plan that has the highest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible; and

(e) the insurer's five most commonly selected health benefit plans that:

(i) include:

(A) the provider panel;

(B) the deductible;

(C) co-payments;

(D) co-insurance; and

(E) pharmacy benefits; and

(ii) have the largest number of enrolled lives in the insurer's own total block of small employer group business in the state.

(2) (a) The provisions of Subsection (1) do not limit the number of defined contribution arrangement health benefit plans an insurer may offer in the defined contribution arrangement market.

(b) An insurer who offers the health benefit plans required by Subsection (1) may also offer any other health benefit plan [~~in the~~] as a defined contribution [~~market~~] arrangement if:

(i) the health benefit plan provides benefits that are [~~actuarially richer~~] of greater actuarial value than the benefits required in [~~Subsection (1)(a).~~] the basic benefit plan; or

(ii) the health benefit plan provides benefits with an aggregate actuarial value that is no lower than the actuarial value of the plan required in Subsection (1)(c).

Section 24. Section **31A-30-207** is amended to read:

**31A-30-207. Rating and underwriting restrictions for health plans in the defined contribution arrangement market.**

(1) The rating and underwriting restrictions for defined benefit plans and for the defined contribution [~~market~~] arrangement health benefit plans offered in the Health Insurance

Exchange defined contribution arrangement market shall be:

(a) for small employer groups, in accordance with Section 31A-30-106.1;

(b) for large employer groups, as determined by the risk adjuster board for participation in the risk adjustment mechanism under Chapter 42, Defined Contribution Risk Adjuster Act; and

(c) established in accordance with the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act[~~, and shall apply to employers who participate in the defined contribution arrangement market~~].

(2) All insurers who participate in the defined contribution market [~~must~~] shall:

(a) participate in the risk adjuster mechanism developed under Chapter 42, Defined Contribution Risk Adjuster Act[~~.~~] for all defined contribution arrangement health benefit plans;

(b) provide the risk adjuster board with:

(i) an employer group's risk factor; and

(ii) carrier enrollment data; and

(c) submit rates to the exchange that are net of commissions.

(3) When an employer group of any size enters the defined contribution arrangement market for either a defined contribution arrangement health benefit plan, or a defined benefit plan, and the employer group has a health plan with an insurer who is participating in the defined contribution arrangement market, the risk factor applied to the employer group when it enters the defined contribution market may not be greater than the employer group's renewal risk factor for the same group of covered employees and the same effective date, as determined by the employer group's insurer.

Section 25. Section **31A-30-208** is repealed and reenacted to read:

**31A-30-208. Enrollment for defined contribution arrangements.**

(1) An insurer offering a health benefit plan in the defined contribution arrangement market:

(a) beginning on or after January 1, 2011, shall allow an employer to enroll in a small

employer defined contribution arrangement plan;

(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer group selecting a defined contribution arrangement health benefit plan on or before January 1, 2012;

(c) shall offer a limited pilot program in which a large employer group may enroll in a defined contribution arrangement market plan that takes effect January 1, 2011;

(d) beginning January 1, 2012, shall allow a large employer group to enroll in the defined contribution arrangement market; and

(e) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) (a) Except as provided in Subsection 31A-30-202.5(2), in accordance with Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined contribution arrangement market.

(b) An insurer may offer new or modify existing products in the defined contribution arrangement market:

(i) on January 1 of each year;

(ii) when required by changes in other law; and

(iii) at other times as established by the risk adjuster board created in Section 31A-42-201.

(c) (i) An insurer shall give the department, the Health Insurance Exchange, and the risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a) or (b).

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

Section 26. Section **31A-30-209** is enacted to read:

**31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**

(1) A producer may be listed on the Health Insurance Exchange as a producer for the defined contribution arrangement market in accordance with Section 63M-1-2504, if the producer is designated as an appointed agent for the defined contribution arrangement market in accordance with Subsection (2).

(2) A producer whose license under this title authorizes the producer to sell defined contribution arrangement health benefit plans may be appointed to the defined contribution arrangement market on the Health Insurance Exchange by the Insurance Department, if the producer:

(a) submits an application to the Insurance Department to be appointed as a producer for the defined contribution arrangement market on the Health Insurance Exchange;

(b) is an appointed agent with the majority of the carriers that offer a defined contribution arrangement health benefit plan on the Health Insurance Exchange; and

(c) has completed a defined contribution arrangement training session that is an approved training session as designated by the commissioner.

Section 27. Section **31A-42-102** is amended to read:

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

As used in this chapter:

(1) "Board" means the board of directors of the Utah Defined Contribution Risk Adjuster created in Section 31A-42-201.

(2) "Defined benefit plan" is as defined in Section 31A-30-202.

[~~(2)~~] (3) "Risk adjuster" means the defined contribution risk adjustment mechanism created in Section 31A-42-201.

Section 28. Section **31A-42-103** is amended to read:

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

This chapter applies to a carrier as defined in Section 31A-30-103 who offers a defined contribution arrangement health benefit plan [~~in a defined contribution arrangement~~] under Chapter 30, Part 2, Defined Contribution Arrangements.

Section 29. Section **31A-42-201** is amended to read:

**31A-42-201. Creation of risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.**

(1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity within the [~~Insurance Department~~] department.

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

(b) [~~The following directors shall be~~] The board of directors shall consist of:

(i) the following directors appointed by the governor with the consent of the Senate:

[~~(i)~~] (A) at least three, but up to five, directors with actuarial experience who represent [~~insurance carriers~~] insurers:

[~~(A)~~] (I) that are participating or have committed to participate in the defined contribution arrangement market in the state; and

[~~(B)~~] (II) including at least one and up to two directors who represent [~~a carrier~~] an insurer that has a small percentage of lives in the defined contribution market;

[~~(ii)~~] (B) one director who represents either an individual employee or employer [~~participant in the defined contribution market~~]; and

[~~(iii)~~] (C) one director [~~appointed by the governor to represent~~] who represents the Office of Consumer Health Services within the Governor's Office of Economic Development;

[~~(iv)~~] (ii) one director representing the [~~Public Employee's Health Benefit Program~~] Public Employees' Benefit and Insurance Program with actuarial experience, chosen by the director of the [~~Public Employee's Health Benefit Program who shall serve as an ex officio member~~] Public Employees' Benefit and Insurance Program; and

[~~(v)~~] (iii) the commissioner, or a representative [~~from the department with actuarial experience~~] of the commissioner who:

(A) is appointed by the commissioner; and

(B) has actuarial experience.

(c) The commissioner, or a representative appointed by the commissioner, [~~who will only have voting privileges~~] may vote only in the event of a tie vote.

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

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

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

(5) (a) [~~Members who are not government employees shall receive no~~] A board member who is not a government employee may not receive compensation or benefits for the members' services.

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

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

(7) [~~Six~~] A majority of the board members [~~are~~] is a quorum for the transaction of business.

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

Section 30. Section **31A-42-202** is amended to read:

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

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

(a) establish the methodology for implementing:

(i) Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements; and

(ii) the participation of:

(A) small employer group defined contribution arrangement health benefit plans; and

(B) large employer group defined contribution arrangement health benefit plans;

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

(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and

(ii) underwriting mechanisms and employer eligibility guidelines:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.

(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual are determined, including:

(i) the identification of an initial rate for a qualified individual based on:

(A) standardized age bands submitted by participating insurers; and

(B) wellness incentives for the individual as permitted by federal law; and

(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and [~~31A-30-106~~] 31A-30-106.1.

(c) The plan adopted under Subsection (2)(a) shall outline how:

(i) premium contributions for qualified individuals shall be submitted to the [~~Internet portal~~] Health Insurance Exchange in the amount determined under Subsection (2)(b); and

(ii) the [~~Internet portal~~] Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's [~~health risk~~] rating factor determined in accordance with the plan.

(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between insurers that:

(i) identifies health care conditions subject to risk adjustment;

(ii) establishes an adjustment amount for each identified health care condition;

(iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and

(iv) computes all risk adjustments.

(e) The board may amend the plan if necessary to:

(i) incorporate large group defined contribution arrangement health benefit plans into the defined contribution arrangement market risk adjuster mechanism created by this chapter;

[~~(i)~~] (ii) maintain the proper functioning and solvency of the defined contribution arrangement market and the risk adjuster mechanism;

[~~(ii)~~] (iii) mitigate significant issues of risk selection; or

[~~(iii)~~] (iv) improve the administration of the risk adjuster mechanism including opening enrollment periodically until January 1, 2011, for the purpose of testing the enrollment and risk adjusting process.

(3) (a) The board shall establish a mechanism in which the participating carriers shall submit their plan base rates, rating factors, and premiums to an independent actuary, appointed by the board, for review prior to the publication of the premium rates on the Health Insurance Exchange.

(b) The actuary appointed by the board shall:

(i) be compensated for the analysis under this section from fees established in accordance with Section 63J-1-504:

(A) assessed by the board; and

(B) paid by all small employer carriers participating in the defined contribution

arrangement market and small employer carriers offering health benefit plans under Chapter 30, Part 1, Individual and Small Employer Group; and

(ii) review the information submitted:

(A) under Subsection (3)(a) for the purpose of verifying the validity of the rates, rating factors, and premiums; and

(B) from carriers offering health benefit plans under Chapter 30, Part 1, Individual and Small Employer Group:

(I) for the purpose of verifying underwriting and rating practices; and

(II) as the actuary determines is necessary.

(c) Fees collected under Subsection (3)(b) shall be used to pay the actuary for the purpose of overseeing market conduct.

(d) The actuary shall:

(i) report aggregate data to the risk adjuster board;

(ii) contact carriers:

(A) to inform a carrier of the actuary's findings regarding the particular carrier; and

(B) to request a carrier to re-calculate or verify base rates, rating factors, and premiums; and

(iii) share the actuary's analysis and data with the department for the purposes described in Section 31A-30-106.1.

(e) A carrier shall re-submit premium rates if the department contacts the carrier under Subsection (3).

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

**CHAPTER 42a. UTAH STATEWIDE RISK ADJUSTER ACT**

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

This chapter is known as the "Utah Statewide Risk Adjuster Act."

Section 32. Section **31A-42a-102** is enacted to read:

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

As used in this chapter:

(1) "Board" means the Utah Statewide Risk Adjuster Board created in Section 31A-42a-201.

(2) "Carrier" has the same meaning as defined in Section 31A-30-103.

Section 33. Section **31A-42a-103** is enacted to read:

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

This chapter applies:

(1) to a carrier that offers a health benefit plan in a defined contribution arrangement under Chapter 30, Part 2, Defined Contribution Arrangements; and

(2) any health benefit plan offered to a small employer group on or after January 1, 2011, including a plan offered to a small employer group not participating in a defined contribution arrangement.

Section 34. Section **31A-42a-201** is enacted to read:

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

(1) There is created the Utah Statewide Risk Adjuster, a nonprofit entity within the Insurance Department.

(2) (a) There is created the Utah Statewide Risk Adjuster Board composed of up to nine members described in Subsection (2)(b).

(b) The board of directors shall consist of:

(i) the following directors appointed by the governor with the consent of the Senate:

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

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

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

(B) one director who represents either an individual employee or employer; and

(C) one director who represents the Office of Consumer Health Services within the

Governor's Office of Economic Development;

(ii) one director representing the Public Employees Health Program with actuarial experience, chosen by the director of the Public Employees Health Program; and

(iii) the commissioner, or a representative of the commissioner who is appointed by the commissioner, and has actuarial experience.

(c) The commissioner, or a representative appointed by the commissioner, may vote only in the event of a tie vote.

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

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

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

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

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

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

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

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

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

(10) (a) The Utah Statewide Risk Adjuster operates under the direction of the board in accordance with rules adopted by the commissioner under Section 31A-42a-204.

(b) The budget for operation of the Utah Statewide Risk Adjuster is subject to the

approval of the board.

Section 35. Section **31A-42a-202** is enacted to read:

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

(1) The Utah Statewide Risk Adjuster Board shall submit to the commissioner a proposed plan of operation for the Utah Statewide Risk Adjuster. The proposed plan of operation shall:

(a) specify how the Utah Statewide Risk Adjuster shall adjust risk for:

(i) the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements; and

(ii) any health benefit plan offered to a small employer group on or after January 1, 2013, including a plan offered to a small employer group not participating in a defined contribution arrangement;

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

(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the Utah Statewide Risk Adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) The proposed plan of operation under Subsection (1) shall include:

(a) for the defined contribution arrangement market:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market;

(ii) employer eligibility guidelines that protect carriers from adverse selection in the defined contribution market; and

(iii) (A) how premium contributions for qualified individuals shall be submitted to the Internet portal in the amount determined under Subsection (2)(b); and

(B) how the Internet portal shall distribute premiums to the carriers selected by

qualified individuals within an employer group based on each individual's health risk factor determined in accordance with the plan;

(b) for the defined contribution arrangement market and for any health benefit plan offered to a small employer group on or after January 1, 2013, including a plan offered to a small employer group not participating in a defined contribution arrangement:

(i) underwriting mechanisms:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect carriers from adverse selection;

(ii) how premium rates for an enrollee are calculated, including:

(A) calculation of an initial rate for an enrollee based on:

(I) standardized age bands submitted by carriers; and

(II) wellness incentives for the individual as permitted by federal law; and

(B) calculation of a group risk factor to be applied to the initial age rate based on the health conditions of all qualified individuals in the same employer group, and for small employer groups, in accordance with Sections 31A-30-105 and 31A-30-106; and

(iii) a mechanism for adjusting risk among carriers that:

(A) identifies health conditions subject to risk adjustment;

(B) establishes an adjustment amount for each identified health condition;

(C) determines the extent to which a carrier has more or fewer individuals with an identified health condition than would be expected; and

(D) calculates all risk adjustments.

Section 36. Section **31A-42a-203** is enacted to read:

**31A-42a-203. Powers and duties of board.**

(1) The Utah Statewide Risk Adjuster Board may:

(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with persons or other organizations for the performance of administrative functions; and

(b) sue or be sued, including taking legal action necessary to implement and enforce rules adopted under Section 31A-42a-204.

(2) In addition to the requirements of Section 31A-42a-202, the Utah Statewide Risk Adjuster Board shall:

(a) as necessary, submit to the commissioner proposed amendments to the proposed plan of operation under Subsection 31A-42a-202(1), and to rules adopted by the commissioner under Section 31A-42a-204, that:

(i) maintain the proper functioning and solvency of the defined contribution arrangement market and promote the viability of health benefit plans offered to small employer groups on or after January 1, 2013, including amendments affecting the calculation of rates, underwriting, and other actuarial functions;

(ii) mitigate significant issues of risk selection; or

(iii) improve how the Utah Statewide Risk Adjuster adjusts risk;

(b) prepare and submit an annual report to the department for inclusion in the department's annual market report, which shall include:

(i) the expenses incurred by the board and by the Utah Statewide Risk Adjuster;

(ii) a description of the types of policies sold in the defined contribution arrangement market;

(iii) the number of insured lives in the defined contribution arrangement market;

(iv) the number of insured lives in health benefit plans that do not include state mandates; and

(v) the effect of risk adjustment rules adopted under Section 31A-42a-204 on:

(A) plans offered in the defined contribution arrangement market; and

(B) plans offered to a small employer group on or after January 1, 2013; and

(c) beginning in 2013 and ending in 2014, report to the Health System Reform Task Force and to the Legislative Management Committee prior to October 1 of each year regarding the board's progress in:

(i) developing the plan required under Section 31A-42a-202;

(ii) expanding choice of plans in the defined contribution arrangement market; and

(iii) expanding access to the defined contribution arrangement market in the Internet portal for large employer groups.

(3) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

Section 37. Section **31A-42a-204** is enacted to read:

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

(1) The commissioner shall, after notice and hearing, adopt the Utah Statewide Risk Adjuster Board's proposed plan of operation, and any amendment thereto, through administrative rulemaking if the commissioner determines that the plan or amendment:

(a) meets the requirements of Sections 31A-42a-202 and 31A-42a-203; and

(b) ensures a fair and reasonable administration of risk by the Utah Statewide Risk Adjuster.

(2) The plan, and any amendment thereto, shall be effective only after adoption by the commissioner as an administrative rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) The commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter, if:

(a) the board fails to submit to the commissioner a proposed plan of operation by January 1, 2013, addressing each of the elements specified in Section 31A-42a-202;

(b) the board fails to submit to the commissioner by September 1, 2012, proposed amendments to rules adopted under this section to implement changes made to this chapter during the 2010 Annual General Session of the Legislature; or

(c) the board fails to submit a proposed amendment to rules adopted under this section within a reasonable period, when requested to do so by the commissioner.

(4) Rules promulgated by the commissioner shall continue in force until modified by the commissioner, by rule, or until superseded by a subsequent plan of operation, or an

amendment to the plan of operation, submitted by the board, approved by the commissioner, and implemented by rule.

Section 38. Section **58-5a-307** is enacted to read:

**58-5a-307. Consumer access to provider charges.**

Beginning January 1, 2011, a podiatric physician licensed under this chapter shall, when requested by a consumer:

(1) make a list of professional charges available for the consumer which includes the podiatric physician's 25 most frequently performed:

(a) clinical procedures or clinical services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 39. Section **58-31b-802** is enacted to read:

**58-31b-802. Consumer access to provider charges.**

Beginning January 1, 2011, a nurse whose license under this chapter authorizes independent practice shall, when requested by a consumer:

(1) make a list of prices charged by the nurse available for the consumer which includes the nurse's 25 most frequently performed:

(a) clinic procedures or clinic services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 40. Section **58-67-804** is enacted to read:

**58-67-804. Consumer access to provider charges.**

Beginning January 1, 2011, a physician licensed under this chapter shall, when requested by a consumer:

(1) make a list of prices charged by the physician available for the consumer which includes the physician's 25 most frequently performed:

(a) clinic procedures or clinic services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 41. Section **58-68-804** is enacted to read:

**58-68-804. Consumer access to provider charges.**

Beginning January 1, 2011, an osteopathic physician licensed under this chapter shall, when requested by a consumer:

(1) make a list of prices charged by the osteopathic physician available for the consumer which includes the osteopathic physician's 25 most frequently performed:

(a) clinic procedures or clinic services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 42. Section **58-69-806** is enacted to read:

**58-69-806. Consumer access to provider charges.**

Beginning January 1, 2011, a dentist licensed under this chapter shall, when requested by a consumer:

(1) make a list of prices charged by the dentist available for the consumer which includes the dentist's 25 most frequently performed:

(a) clinic procedures or clinic services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 43. Section **58-73-603** is enacted to read:

**58-73-603. Consumer access to provider charges.**

Beginning January 1, 2011, a chiropractic physician licensed under this chapter shall, when requested by a consumer:

(1) make a list of professional charges available for the consumer which includes the chiropractic physician's 25 most frequently performed:

(a) clinical procedures or clinical services;

(b) out-patient procedures; and

(c) in-patient procedures; and

(2) provide the consumer with information regarding any discount available for:

(a) services not covered by insurance; or

(b) prompt payment of billed charges.

Section 44. Section **63I-1-231** is amended to read:

**63I-1-231. Repeal dates, Title 31A.**

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2010.

(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.

(3) Section 31A-22-315, Motor vehicle insurance reporting -- Penalty, is repealed July 1, 2010.

(4) Section 31A-22-625, Catastrophic coverage of mental health conditions, is repealed July 1, 2011.

(5) Chapter 42a, Utah Statewide Risk Adjuster Act, is repealed July 1, 2016.

Section 45. Section **63I-2-231** is amended to read:

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

(1) Section 31A-23a-415 is repealed July 1, 2011.

(2) Section 31A-22-619 is repealed July 1, 2010.

(3) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed January 1, 2013.

Section 46. 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 [~~an Internet portal~~] a Health Insurance Exchange that:

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

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the [~~Internet portal~~] Health Insurance Exchange by an insurer for the:

(A) small employer group market;

(B) the individual market; and

(C) the defined contribution arrangement market; and

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

(b) facilitate a private sector method for 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 by educating employers and insurers about collection services available through private vendors, including financial institutions;

(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) periodically convene health care providers, payers, and consumers to monitor the progress being made regarding demonstration projects for health care delivery and payment reform; [~~and~~]

(e) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the defined contribution arrangement market on the Health Insurance Exchange; and

[~~(c)~~] (f) report to the Business and Labor Interim Committee and the Health System Reform Task Force prior to [~~November 1, 2009 and~~] November 1, 2010, and prior to the Legislative interim day in November of each year thereafter regarding:

(i) the operations of the [~~Internet portal~~] Health Insurance Exchange required by this chapter; and

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

(3) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, or health insurance producers;

(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; and

(b) may establish and collect a fee in accordance with Section 63J-1-504 for the transaction cost of:

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

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

Section 47. Section **63M-1-2506** is amended to read:

**63M-1-2506. Health benefit plan information on Health Insurance Exchange --**

**Insurer transparency.**

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

(i) establish uniform electronic standards for:

(A) a health insurer to use when:

(I) transmitting information to [~~the Internet portal; or~~]:

(Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and

(Bb) the Health Insurance Exchange as required by this section;

(II) receiving information from the [~~Internet portal; and~~] Health Insurance Exchange;

(III) receiving or transmitting the universal health application to or from the Health Insurance Exchange;

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

(C) the use of the uniform health insurance application required by Section 31A-22-635 on the Health Insurance Exchange;

(ii) designate the level of detail that would be helpful for a concise consumer comparison of the items described in Subsections (4)[~~(a) through (d)~~] and (5) on the [~~Internet portal~~] Health Insurance Exchange; [~~and~~]

(iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on the [~~Internet portal~~] Health Insurance Exchange with the determination of when an employer is eligible to participate in the [~~Internet portal defined contribution market~~] Health Insurance Exchange under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements[~~.~~]; and

(iv) create an advisory board to advise the exchange concerning the operation of the exchange and transparency issues with the following members:

(A) two health producers who are registered with the Health Insurance Exchange;

(B) two consumers;

(C) one representative from a large insurer who participates on the exchange;

(D) one representative from a small insurer who participates on the exchange;

(E) one representative from the Insurance Department; and

(F) one representative from the Department of Health.

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

(i) the information required by this section on the [~~Internet portal~~] Health Insurance Exchange created by this part; and

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

(2) A health insurer shall use the uniform electronic standards when transmitting information to the [~~Internet portal~~] Health Insurance Exchange or receiving information from the [~~Internet portal~~] Health Insurance Exchange.

(3) (a) (i) An insurer who participates in the defined contribution arrangement market under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans offered in [~~that~~] the defined contribution arrangement market on the [~~Internet portal~~] Health Insurance Exchange and shall comply with the provisions of this section.

(ii) Beginning January 1, 2013, an insurer who offers a health benefit plan to a small employer group in the state shall:

(A) post the health benefit plans in which the insurer is enrolling new groups on the Health Insurance Exchange; and

(B) comply with the provisions of this section.

(b) An insurer who offers [~~products~~] individual health benefit plans under Title 31A, Chapter 30, Part 1, Individual and Small Employer Group:

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

(ii) may publish on the Health Insurance Exchange any other health benefit plans that

it offers [~~on the Internet portal; and~~] in the individual market.

(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:

[~~(iii)~~] (i) shall comply with the provisions of this section for every health benefit plan it posts on the [~~Internet portal.~~] Health Insurance Exchange; and

(ii) may not offer products on the Health Insurance Exchange that are not health benefit plans.

(4) A health insurer shall provide the [~~Internet portal~~] Health Insurance Exchange with the following information for each health benefit plan submitted to the [~~Internet portal~~] Health Insurance Exchange:

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

(b) provider networks;

(c) wellness programs and incentives; and

(d) descriptions of prescription drug benefits, exclusions, or limitations[~~; and~~].

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

(5) (a) An insurer offering any health benefit plan in the state shall submit the information described in Subsection (5)(b) to the Insurance Department in the electronic format required by Subsection (1).

(b) An insurer who offers a health benefit plan in the state shall submit to the Health Insurance Exchange the following operational measures:

(i) 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

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

(ii) for all health benefit plans offered by the insurer in the state, the claims denial and

insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).

(c) The Insurance Department shall forward to the Health Insurance Exchange the information submitted by an insurer in accordance with this section and Section 31A-22-613.5.

[~~(5)~~] (6) The Insurance Department shall post on the [~~Internet portal~~] Health Insurance Exchange the Insurance Department's solvency rating for each insurer who posts a health benefit plan on the [~~Internet portal~~] Health Insurance Exchange. The solvency rating for each carrier shall be based on methodology established by the Insurance Department by administrative rule and shall be updated each calendar year.

[~~(6)~~] (7) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the [~~Internet portal~~] Insurance Department and to the Health Insurance Exchange under this section.

[~~(7)~~] (8) A health insurer shall accept and process an application for a health benefit plan from the [~~Internet portal~~] Health Insurance Exchange in accordance with this section and Section 31A-22-635.

Section 48. **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 co-chair 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 co-chair 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 49. **Duties -- Interim report.**

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

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

(b) the implementation of statewide demonstration projects to provide systemwide aligned incentives for the appropriate delivery of and payment for health care;

(c) the development of the defined contribution arrangement market and the plan developed by the risk adjuster board for implementation by January 1, 2012, including:

(i) consumer experience and plan selection in the defined contribution market;

(ii) participation by large employer groups in the defined contribution market; and

(iii) risk allocation in the defined contribution market including the study of implementing an individual health risk score;

(d) the operations and progress of the Health Insurance Exchange;

(e) mechanisms to increase transparency in the insurance market;

(f) the implementation and effectiveness of insurer wellness programs and incentives, including outcome measures for the programs;

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

(h) the role that the Public Employees' Benefit and Insurance Program and other associations that provide insurance may play in the defined contribution market;

(i) the development of strategies to keep community leaders, business leaders, and the

public involved in the process of health care reform; and

(j) the state's response to, and duties under, federal health care reform.

(2) A final report shall be presented to the Business and Labor Interim Committee before November 30, 2010.

Section 50. **Effective date.**

(1) Except as provided in Subsections (2) and (3), if approved by two-thirds of all the members elected to each house, this bill takes effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override, except that the amendments to Sections 31A-30-103 and 31A-30-106 take effect on January 1, 2011.

(2) The amendments to Section 31A-3-304 (Effective 07/01/10) take effect July 1, 2010.

(3) The following sections take effect on January 1, 2013:

(a) Section 31A-42a-101;

(b) Section 31A-42a-102;

(c) Section 31A-42a-103;

(d) Section 31A-42a-201;

(e) Section 31A-42a-202;

(f) Section 31A-42a-203; and

(g) Section 31A-42a-204.