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Field Code Changed

HEALTH SYSTEM REFORM - INSURANCE

MARKET

2009 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill amends the Insurance Code to expand access to the health insurance market, stabilize premiums, and create insurance market flexibility.

Highlighted Provisions:

This bill:

- ▶ ~~repeals the guarantee issue and community rating provisions in the insurance code~~
▶ establishes requirements for insurer transparency of plan benefits and offerings;
- ▶ gives the insurance commissioner rule making authority to adopt standards for the electronic submission of health plan information to the Internet portal;
- ▶ establishes a new basic benefit package called the Utah NetCare Basic Health Care Plan which includes:
 - a low and high deductible plan;
 - first dollar coverage for certain benefits; and
 - lower premiums;
- ▶ amends the exemptions from health insurance standards to facilitate a mandate-free, low-cost product;
- ▶ authorizes a preferred provider organization and a health maintenance organization to offer a new health benefit plan that does not include certain state mandated benefits;
- ▶ authorizes an employer to offer the Utah NetCare Basic Health Care Plan as alternative coverage for state mini-COBRA coverage, federal COBRA coverage, and a conversion plan;
- ▶ requires health insurance producers to disclose payment of commissions to a

*** PROTECTED ***

- 32 customer prior to the customer's purchase or renewal of a health benefit plan;
- 33 ▶ establishes a defined contribution arrangement which:
- 34 · requires an insurer to offer products through the Internet portal and through a
- 35 defined contribution arrangement before an insurer may offer products that are
- 36 not subject to state mandates;
- 37 · permits small employers, large employers, and ERISA plans to participate;
- 38 · requires employers who wish to participate to establish Section 125 plans that
- 39 allow pre-tax dollars for premium payments;
- 40 · gives the employees of a participating employer the option to choose either a
- 41 plan from the Internet portal, a plan selected by the employer, or no coverage;
- 42 · prohibits an insurer from establishing, as a condition for coverage, an employer
- 43 minimum contribution level;
- 44 · permits an insurer to require minimum participation of eligible employees as a
- 45 condition of coverage;
- 46 · requires the insurer to accept premium payments from multiple sources,
- 47 including government assistance and contributions from other employers;
- 48 · permits underwriting in the defined contribution arrangements based only on
- 49 age, geography and family composition; and
- 50 · requires insurers offering products through defined contribution arrangements to
- 51 participate in a risk adjustment mechanism; and
- 52 ▶ establishes the Utah Health Re-Insurance Pool as a risk adjuster mechanism for
- 53 defined contribution arrangements which includes:
- 54 · creating the pool as a non-profit entity within the Department of Insurance;
- 55 · establishing a governing board for the pool;
- 56 · requiring the board to adopt a plan of operation;
- 57 · establishing powers of the board;
- 58 · establishing oversight powers for the insurance commissioner;
- 59 · requiring the board to select a pool administrator;
- 60 · establishing eligibility for pool membership and ceding risk to the pool;
- 61 · authorizing assessments for the pool; and
- 62 · creating the Utah Health Re-Insurance Pool Enterprise Fund.

63 **Monies Appropriated in this Bill:**

*** PROTECTED ***

64 None

65 **Other Special Clauses:**

66 None

67 **Utah Code Sections Affected:**

68 AMENDS:

69 **31A-1-301**, as last amended by Laws of Utah 2008, Chapters 345 and 382

70 **31A-8-501**, as last amended by Laws of Utah 2004, Chapters 90, 229, and 367

71 **31A-22-613.5**, as last amended by Laws of Utah 2008, Chapters 241 and 345

72 **31A-22-614.5**, as last amended by Laws of Utah 2008, Chapters 379 and 382

73 **31A-22-633**, as last amended by Laws of Utah 2005, Chapter 123

74 **31A-22-722**, as last amended by Laws of Utah 2006, Chapter 188

75 **31A-22-723**, as last amended by Laws of Utah 2008, Chapters 241 and 250

76 **31A-23a-401**, as last amended by Laws of Utah 2007, Chapter 307

77 **31A-23a-501**, as renumbered and amended by Laws of Utah 2003, Chapter 298

78 **31A-30-102**, as last amended by Laws of Utah 2008, Chapter 345

79 **31A-30-103**, as last amended by Laws of Utah 2007, Chapter 307

80 **31A-30-107**, as last amended by Laws of Utah 2004, Chapter 329

81 **31A-30-112**, as last amended by Laws of Utah 2008, Chapter 345

82 ENACTS:

83 **31A-22-618.5**, Utah Code Annotated 1953

84 **31A-22-724**, Utah Code Annotated 1953

85 **31A-30-201**, Utah Code Annotated 1953

86 **31A-30-202**, Utah Code Annotated 1953

87 **31A-30-203**, Utah Code Annotated 1953

88 **31A-30-204**, Utah Code Annotated 1953

89 **31A-42-101**, Utah Code Annotated 1953

90 **31A-42-102**, Utah Code Annotated 1953

91 **31A-42-103**, Utah Code Annotated 1953

92 **31A-42-201**, Utah Code Annotated 1953

*** PROTECTED ***

- 93 **31A-42-202**, Utah Code Annotated 1953
- 94 **31A-42-203**, Utah Code Annotated 1953
- 95 **31A-42-204**, Utah Code Annotated 1953
- 96 **31A-42-205**, Utah Code Annotated 1953
- 97 **31A-42-206**, Utah Code Annotated 1953
- 98 **31A-42-207**, Utah Code Annotated 1953
- 99 **31A-42-208**, Utah Code Annotated 1953
- 100 **31A-42-209**, Utah Code Annotated 1953

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

102 Section 1. Section **31A-1-301** is amended to read:

104 **31A-1-301. Definitions.**

105 As used in this title, unless otherwise specified:

106 (1) (a) "Accident and health insurance" means insurance to provide protection against
107 economic losses resulting from:

108 (i) a medical condition including:

- 109 (A) a medical care expense; or
- 110 (B) the risk of disability;

111 (ii) accident; or

112 (iii) sickness.

113 (b) "Accident and health insurance":

114 (i) includes a contract with disability contingencies including:

- 115 (A) an income replacement contract;
- 116 (B) a health care contract;
- 117 (C) an expense reimbursement contract;
- 118 (D) a credit accident and health contract;
- 119 (E) a continuing care contract; and
- 120 (F) a long-term care contract; and

121 (ii) may provide:

- 122 (A) hospital coverage;
- 123 (B) surgical coverage;
- 124 (C) medical coverage;
- 125 (D) loss of income coverage;

126 (E) prescription drug coverage;

127 (F) dental coverage; or

128 (G) vision coverage.

129 (c) "Accident and health insurance" does not include workers' compensation insurance.

130 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title

131 63G, Chapter 3, Utah Administrative Rulemaking Act.

132 (3) "Administrator" is defined in Subsection (159).

133 (4) "Adult" means a natural person who has attained the age of at least 18 years.

134 (5) "Affiliate" means a person who controls, is controlled by, or is under common

135 control with, another person. A corporation is an affiliate of another corporation, regardless of

136 ownership, if substantially the same group of natural persons manages the corporations.

137 (6) "Agency" means:

138 (a) a person other than an individual, including a sole proprietorship by which a natural

139 person does business under an assumed name; and

140 (b) an insurance organization licensed or required to be licensed under Section 31A-

141 23a-301.

142 (7) "Alien insurer" means an insurer domiciled outside the United States.

143 (8) "Amendment" means an endorsement to an insurance policy or certificate.

144 (9) "Annuity" means an agreement to make periodical payments for a period certain or

145 over the lifetime of one or more natural persons if the making or continuance of all or some of

146 the series of the payments, or the amount of the payment, is dependent upon the continuance of

147 human life.

148 (10) "Application" means a document:

149 (a) (i) completed by an applicant to provide information about the risk to be insured;

150 and

151 (ii) that contains information that is used by the insurer to evaluate risk and decide

152 whether to:

153 (A) insure the risk under:

154 (I) the coverage as originally offered; or

155 (II) a modification of the coverage as originally offered; or

156 (B) decline to insure the risk; or

157 (b) used by the insurer to gather information from the applicant before issuance of an

158 annuity contract.

159 (11) "Articles" or "articles of incorporation" means:

160 (a) the original articles;
161 (b) a special law;
162 (c) a charter;
163 (d) an amendment;
164 (e) restated articles;
165 (f) articles of merger or consolidation;
166 (g) a trust instrument;
167 (h) another constitutive document for a trust or other entity that is not a corporation;
168 and
169 (i) an amendment to an item listed in Subsections (11)(a) through (h).
170 (12) "Bail bond insurance" means a guarantee that a person will attend court when
171 required, up to and including surrender of the person in execution of a sentence imposed under
172 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
173 (13) "Binder" is defined in Section 31A-21-102.
174 (14) "Blanket insurance policy" means a group policy covering a defined class of
175 persons:
176 (a) without individual underwriting or application; and
177 (b) that is determined by definition with or without designating each person covered.
178 (15) "Board," "board of trustees," or "board of directors" means the group of persons
179 with responsibility over, or management of, a corporation, however designated.
180 (16) "Business entity" means:
181 (a) a corporation;
182 (b) an association;
183 (c) a partnership;
184 (d) a limited liability company;
185 (e) a limited liability partnership; or
186 (f) another legal entity.
187 (17) "Business of insurance" is defined in Subsection (85).
188 (18) "Business plan" means the information required to be supplied to the
189 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
190 when these subsections apply by reference under:
191 (a) Section 31A-7-201;
192 (b) Section 31A-8-205; or
193 (c) Subsection 31A-9-205(2).

194 (19) (a) "Bylaws" means the rules adopted for the regulation or management of a
195 corporation's affairs, however designated.

196 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
197 corporation.

198 (20) "Captive insurance company" means:

199 (a) an insurer:

200 (i) owned by another organization; and

201 (ii) whose exclusive purpose is to insure risks of the parent organization and an
202 affiliated company; or

203 (b) in the case of a group or association, an insurer:

204 (i) owned by the insureds; and

205 (ii) whose exclusive purpose is to insure risks of:

206 (A) a member organization;

207 (B) a group member; or

208 (C) an affiliate of:

209 (I) a member organization; or

210 (II) a group member.

211 (21) "Casualty insurance" means liability insurance as defined in Subsection (97).

212 (22) "Certificate" means evidence of insurance given to:

213 (a) an insured under a group insurance policy; or

214 (b) a third party.

215 (23) "Certificate of authority" is included within the term "license."

216 (24) "Claim," unless the context otherwise requires, means a request or demand on an
217 insurer for payment of a benefit according to the terms of an insurance policy.

218 (25) "Claims-made coverage" means an insurance contract or provision limiting
219 coverage under a policy insuring against legal liability to claims that are first made against the
220 insured while the policy is in force.

221 (26) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
222 commissioner.

223 (b) When appropriate, the terms listed in Subsection (26)(a) apply to the equivalent
224 supervisory official of another jurisdiction.

225 (27) (a) "Continuing care insurance" means insurance that:

226 (i) provides board and lodging;

227 (ii) provides one or more of the following:

228 (A) a personal service;
229 (B) a nursing service;
230 (C) a medical service; or
231 (D) any other health-related service; and
232 (iii) provides the coverage described in Subsection (27)(a)(i) under an agreement
233 effective:
234 (A) for the life of the insured; or
235 (B) for a period in excess of one year.
236 (b) Insurance is continuing care insurance regardless of whether or not the board and
237 lodging are provided at the same location as a service described in Subsection (27)(a)(ii).
238 (28) (a) "Control," "controlling," "controlled," or "under common control" means the
239 direct or indirect possession of the power to direct or cause the direction of the management
240 and policies of a person. This control may be:
241 (i) by contract;
242 (ii) by common management;
243 (iii) through the ownership of voting securities; or
244 (iv) by a means other than those described in Subsections (28)(a)(i) through (iii).
245 (b) There is no presumption that an individual holding an official position with another
246 person controls that person solely by reason of the position.
247 (c) A person having a contract or arrangement giving control is considered to have
248 control despite the illegality or invalidity of the contract or arrangement.
249 (d) There is a rebuttable presumption of control in a person who directly or indirectly
250 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
251 voting securities of another person.
252 (29) "Controlled insurer" means a licensed insurer that is either directly or indirectly
253 controlled by a producer.
254 (30) "Controlling person" means a person that directly or indirectly has the power to
255 direct or cause to be directed, the management, control, or activities of a reinsurance
256 intermediary.
257 (31) "Controlling producer" means a producer who directly or indirectly controls an
258 insurer.
259 (32) (a) "Corporation" means an insurance corporation, except when referring to:
260 (i) a corporation doing business:
261 (A) as:

262 (I) an insurance producer;

263 (II) a limited line producer;

264 (III) a consultant;

265 (IV) a managing general agent;

266 (V) a reinsurance intermediary;

267 (VI) a third party administrator; or

268 (VII) an adjuster; and

269 (B) under:

270 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and

271 Reinsurance Intermediaries;

272 (II) Chapter 25, Third Party Administrators; or

273 (III) Chapter 26, Insurance Adjusters; or

274 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance

275 Holding Companies.

276 (b) "Stock corporation" means a stock insurance corporation.

277 (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.

278 (33) "Creditable coverage" has the same meaning as provided in federal regulations

279 adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L.

280 104-191, 110 Stat. 1936.

281 (34) "Credit accident and health insurance" means insurance on a debtor to provide

282 indemnity for payments coming due on a specific loan or other credit transaction while the

283 debtor is disabled.

284 (35) (a) "Credit insurance" means insurance offered in connection with an extension of

285 credit that is limited to partially or wholly extinguishing that credit obligation.

286 (b) "Credit insurance" includes:

287 (i) credit accident and health insurance;

288 (ii) credit life insurance;

289 (iii) credit property insurance;

290 (iv) credit unemployment insurance;

291 (v) guaranteed automobile protection insurance;

292 (vi) involuntary unemployment insurance;

293 (vii) mortgage accident and health insurance;

294 (viii) mortgage guaranty insurance; and

295 (ix) mortgage life insurance.

296 (36) "Credit life insurance" means insurance on the life of a debtor in connection with
297 an extension of credit that pays a person if the debtor dies.

298 (37) "Credit property insurance" means insurance:

299 (a) offered in connection with an extension of credit; and

300 (b) that protects the property until the debt is paid.

301 (38) "Credit unemployment insurance" means insurance:

302 (a) offered in connection with an extension of credit; and

303 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:

304 (i) specific loan; or

305 (ii) credit transaction.

306 (39) "Creditor" means a person, including an insured, having a claim, whether:

307 (a) matured;

308 (b) unmatured;

309 (c) liquidated;

310 (d) unliquidated;

311 (e) secured;

312 (f) unsecured;

313 (g) absolute;

314 (h) fixed; or

315 (i) contingent.

316 (40) (a) "Customer service representative" means a person that provides an insurance
317 service and insurance product information:

318 (i) for the customer service representative's:

319 (A) producer; or

320 (B) consultant employer; and

321 (ii) to the customer service representative's employer's:

322 (A) customer;

323 (B) client; or

324 (C) organization.

325 (b) A customer service representative may only operate within the scope of authority
326 of the customer service representative's producer or consultant employer.

327 (41) "Deadline" means the final date or time:

328 (a) imposed by:

329 (i) statute;

330 (ii) rule; or
331 (iii) order; and
332 (b) by which a required filing or payment must be received by the department.
333 (42) "Deemer clause" means a provision under this title under which upon the
334 occurrence of a condition precedent, the commissioner is considered to have taken a specific
335 action. If the statute so provides, a condition precedent may be the commissioner's failure to
336 take a specific action.
337 (43) "Degree of relationship" means the number of steps between two persons
338 determined by counting the generations separating one person from a common ancestor and
339 then counting the generations to the other person.
340 (44) "Department" means the Insurance Department.
341 (45) "Director" means a member of the board of directors of a corporation.
342 (46) "Disability" means a physiological or psychological condition that partially or
343 totally limits an individual's ability to:
344 (a) perform the duties of:
345 (i) that individual's occupation; or
346 (ii) any occupation for which the individual is reasonably suited by education, training,
347 or experience; or
348 (b) perform two or more of the following basic activities of daily living:
349 (i) eating;
350 (ii) toileting;
351 (iii) transferring;
352 (iv) bathing; or
353 (v) dressing.
354 (47) "Disability income insurance" is defined in Subsection (76).
355 (48) "Domestic insurer" means an insurer organized under the laws of this state.
356 (49) "Domiciliary state" means the state in which an insurer:
357 (a) is incorporated;
358 (b) is organized; or
359 (c) in the case of an alien insurer, enters into the United States.
360 (50) (a) "Eligible employee" means:
361 (i) an employee who:
362 (A) works on a full-time basis; and
363 (B) has a normal work week of 30 or more hours; or

364 (ii) a person described in Subsection (50)(b).
365 (b) "Eligible employee" includes, if the individual is included under a health benefit
366 plan of a small employer:
367 (i) a sole proprietor;
368 (ii) a partner in a partnership; or
369 (iii) an independent contractor.
370 (c) "Eligible employee" does not include, unless eligible under Subsection (50)(b):
371 (i) an individual who works on a temporary or substitute basis for a small employer;
372 (ii) an employer's spouse; or
373 (iii) a dependent of an employer.
374 (51) "Employee" means an individual employed by an employer.
375 (52) "Employee benefits" means one or more benefits or services provided to:
376 (a) an employee; or
377 (b) a dependent of an employee.
378 (53) (a) "Employee welfare fund" means a fund:
379 (i) established or maintained, whether directly or through a trustee, by:
380 (A) one or more employers;
381 (B) one or more labor organizations; or
382 (C) a combination of employers and labor organizations; and
383 (ii) that provides employee benefits paid or contracted to be paid, other than income
384 from investments of the fund:
385 (A) by or on behalf of an employer doing business in this state; or
386 (B) for the benefit of a person employed in this state.
387 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
388 revenues.
389 (54) "Endorsement" means a written agreement attached to a policy or certificate to
390 modify one or more of the provisions of the policy or certificate.
391 (55) "Enrollment date," with respect to a health benefit plan, means:
392 (a) the first day of coverage; or
393 (b) if there is a waiting period, the first day of the waiting period.
394 (56) (a) "Escrow" means:
395 (i) a real estate settlement or real estate closing conducted by a third party pursuant to
396 the requirements of a written agreement between the parties in a real estate transaction; or
397 (ii) a settlement or closing involving:

398 (A) a mobile home;
399 (B) a grazing right;
400 (C) a water right; or
401 (D) other personal property authorized by the commissioner.
402 (b) "Escrow" includes the act of conducting a:
403 (i) real estate settlement; or
404 (ii) real estate closing.
405 (57) "Escrow agent" means:
406 (a) an insurance producer with:
407 (i) a title insurance line of authority; and
408 (ii) an escrow subline of authority; or
409 (b) a person defined as an escrow agent in Section 7-22-101.
410 (58) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
411 excluded.
412 (b) The items listed in a list using the term "excludes" are representative examples for
413 use in interpretation of this title.
414 (59) "Exclusion" means for the purposes of accident and health insurance that an
415 insurer does not provide insurance coverage, for whatever reason, for one of the following:
416 (a) a specific physical condition;
417 (b) a specific medical procedure;
418 (c) a specific disease or disorder; or
419 (d) a specific prescription drug or class of prescription drugs.
420 (60) "Expense reimbursement insurance" means insurance:
421 (a) written to provide a payment for an expense relating to hospital confinement
422 resulting from illness or injury; and
423 (b) written:
424 (i) as a daily limit for a specific number of days in a hospital; and
425 (ii) to have a one or two day waiting period following a hospitalization.
426 (61) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
427 a position of public or private trust.
428 (62) (a) "Filed" means that a filing is:
429 (i) submitted to the department as required by and in accordance with applicable
430 statute, rule, or filing order;
431 (ii) received by the department within the time period provided in applicable statute,

*** PROTECTED ***

432 rule, or filing order; and

433 (iii) accompanied by the appropriate fee in accordance with:

434 (A) Section 31A-3-103; or

435 (B) rule.

436 (b) "Filed" does not include a filing that is rejected by the department because it is not

437 submitted in accordance with Subsection (62)(a).

438 (63) "Filing," when used as a noun, means an item required to be filed with the

439 department including:

440 (a) a policy;

441 (b) a rate;

442 (c) a form;

443 (d) a document;

444 (e) a plan;

445 (f) a manual;

446 (g) an application;

447 (h) a report;

448 (i) a certificate;

449 (j) an endorsement;

450 (k) an actuarial certification;

451 (l) a licensee annual statement;

452 (m) a licensee renewal application;

453 (n) an advertisement; or

454 (o) an outline of coverage.

455 (64) "First party insurance" means an insurance policy or contract in which the insurer

456 agrees to pay a claim submitted to it by the insured for the insured's losses.

457 (65) "Foreign insurer" means an insurer domiciled outside of this state, including an

458 alien insurer.

459 (66) (a) "Form" means one of the following prepared for general use:

460 (i) a policy;

461 (ii) a certificate;

462 (iii) an application;

463 (iv) an outline of coverage; or

464 (v) an endorsement.

465 (b) "Form" does not include a document specially prepared for use in an individual
466 case.

467 (67) "Franchise insurance" means an individual insurance policy provided through a
468 mass marketing arrangement involving a defined class of persons related in some way other
469 than through the purchase of insurance.

470 (68) "General lines of authority" include:

471 (a) the general lines of insurance in Subsection (69);

472 (b) title insurance under one of the following sublines of authority:

473 (i) search, including authority to act as a title marketing representative;

474 (ii) escrow, including authority to act as a title marketing representative;

475 (iii) search and escrow, including authority to act as a title marketing representative;

476 and

477 (iv) title marketing representative only;

478 (c) surplus lines;

479 (d) workers' compensation; and

480 (e) any other line of insurance that the commissioner considers necessary to recognize
481 in the public interest.

482 (69) "General lines of insurance" include:

483 (a) accident and health;

484 (b) casualty;

485 (c) life;

486 (d) personal lines;

487 (e) property; and

488 (f) variable contracts, including variable life and annuity.

489 (70) "Group health plan" means an employee welfare benefit plan to the extent that the
490 plan provides medical care:

491 (a) (i) to an employee; or

492 (ii) to a dependent of an employee; and

493 (b) (i) directly;

494 (ii) through insurance reimbursement; or

495 (iii) through another method.

496 (71) (a) "Group insurance policy" means a policy covering a group of persons that is
497 issued:

498 (i) to a policyholder on behalf of the group; and
499 (ii) for the benefit of a member of the group who is selected under a procedure defined
500 in:

501 (A) the policy; or

502 (B) an agreement that is collateral to the policy.

503 (b) A group insurance policy may include a member of the policyholder's family or a
504 dependent.

505 (72) "Guaranteed automobile protection insurance" means insurance offered in
506 connection with an extension of credit that pays the difference in amount between the
507 insurance settlement and the balance of the loan if the insured automobile is a total loss.

508 (73) (a) Except as provided in Subsection (73)(b), "health benefit plan" means a policy
509 or certificate that:

510 (i) provides health care insurance;

511 (ii) provides major medical expense insurance; or

512 (iii) is offered as a substitute for hospital or medical expense insurance such as:

513 (A) a hospital confinement indemnity; or

514 (B) a limited benefit plan.

515 (b) "Health benefit plan" does not include a policy or certificate that:

516 (i) provides benefits solely for:

517 (A) accident;

518 (B) dental;

519 (C) income replacement;

520 (D) long-term care;

521 (E) a Medicare supplement;

522 (F) a specified disease;

523 (G) vision; or

524 (H) a short-term limited duration; or

525 (ii) is offered and marketed as supplemental health insurance.

526 (74) "Health care" means any of the following intended for use in the diagnosis,
527 treatment, mitigation, or prevention of a human ailment or impairment:

528 (a) a professional service;

529 (b) a personal service;

530 (c) a facility;

531 (d) equipment;

532 (e) a device;
533 (f) supplies; or
534 (g) medicine.

535 (75) (a) "Health care insurance" or "health insurance" means insurance providing:
536 (i) a health care benefit; or
537 (ii) payment of an incurred health care expense.

538 (b) "Health care insurance" or "health insurance" does not include accident and health
539 insurance providing a benefit for:
540 (i) replacement of income;
541 (ii) short-term accident;
542 (iii) fixed indemnity;
543 (iv) credit accident and health;
544 (v) supplements to liability;
545 (vi) workers' compensation;
546 (vii) automobile medical payment;
547 (viii) no-fault automobile;
548 (ix) equivalent self-insurance; or
549 (x) a type of accident and health insurance coverage that is a part of or attached to
550 another type of policy.

551 (76) "Income replacement insurance" or "disability income insurance" means
552 insurance written to provide payments to replace income lost from accident or sickness.

553 (77) "Indemnity" means the payment of an amount to offset all or part of an insured
554 loss.

555 (78) "Independent adjuster" means an insurance adjuster required to be licensed under
556 Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

557 (79) "Independently procured insurance" means insurance procured under Section
558 31A-15-104.

559 (80) "Individual" means a natural person.

560 (81) "Inland marine insurance" includes insurance covering:
561 (a) property in transit on or over land;
562 (b) property in transit over water by means other than boat or ship;
563 (c) bailee liability;
564 (d) fixed transportation property such as bridges, electric transmission systems, radio
565 and television transmission towers and tunnels; and

566 (e) personal and commercial property floaters.

567 (82) "Insolvency" means that:

568 (a) an insurer is unable to pay its debts or meet its obligations as the debts and
569 obligations mature;

570 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
571 RBC under Subsection 31A-17-601(8)(c); or

572 (c) an insurer is determined to be hazardous under this title.

573 (83) (a) "Insurance" means:

574 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
575 persons to one or more other persons; or

576 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
577 group of persons that includes the person seeking to distribute that person's risk.

578 (b) "Insurance" includes:

579 (i) a risk distributing arrangement providing for compensation or replacement for
580 damages or loss through the provision of a service or a benefit in kind;

581 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
582 business and not as merely incidental to a business transaction; and

583 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
584 but with a class of persons who have agreed to share the risk.

585 (84) "Insurance adjuster" means a person who directs the investigation, negotiation, or
586 settlement of a claim under an insurance policy other than life insurance or an annuity, on
587 behalf of an insurer, policyholder, or a claimant under an insurance policy.

588 (85) "Insurance business" or "business of insurance" includes:

589 (a) providing health care insurance, as defined in Subsection (75), by an organization
590 that is or should be licensed under this title;

591 (b) providing a benefit to an employee in the event of a contingency not within the
592 control of the employee, in which the employee is entitled to the benefit as a right, which
593 benefit may be provided either:

594 (i) by a single employer or by multiple employer groups; or

595 (ii) through one or more trusts, associations, or other entities;

596 (c) providing an annuity:

597 (i) including an annuity issued in return for a gift; and

598 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)
599 and (3);

600 (d) providing the characteristic services of a motor club as outlined in Subsection
601 (113);

602 (e) providing another person with insurance as defined in Subsection (83);

603 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
604 or surety, a contract or policy of title insurance;

605 (g) transacting or proposing to transact any phase of title insurance, including:

606 (i) solicitation;

607 (ii) negotiation preliminary to execution;

608 (iii) execution of a contract of title insurance;

609 (iv) insuring; and

610 (v) transacting matters subsequent to the execution of the contract and arising out of
611 the contract, including reinsurance; and

612 (h) doing, or proposing to do, any business in substance equivalent to Subsections
613 (85)(a) through (g) in a manner designed to evade the provisions of this title.

614 (86) "Insurance consultant" or "consultant" means a person who:

615 (a) advises another person about insurance needs and coverages;

616 (b) is compensated by the person advised on a basis not directly related to the
617 insurance placed; and

618 (c) except as provided in Section 31A-23a-501, is not compensated directly or
619 indirectly by an insurer or producer for advice given.

620 (87) "Insurance holding company system" means a group of two or more affiliated
621 persons, at least one of whom is an insurer.

622 (88) (a) "Insurance producer" or "producer" means a person licensed or required to be
623 licensed under the laws of this state to sell, solicit, or negotiate insurance.

624 (b) With regards to the selling, soliciting, or negotiating of an insurance product to an
625 insurance customer or an insured:

626 (i) "producer for the insurer" means a producer who is compensated directly or
627 indirectly by an insurer for selling, soliciting, or negotiating a product of that insurer; and

628 (ii) "producer for the insured" means a producer who:

629 (A) is compensated directly and only by an insurance customer or an insured; and

630 (B) receives no compensation directly or indirectly from an insurer for selling,
631 soliciting, or negotiating a product of that insurer to an insurance customer or insured.

632 (89) (a) "Insured" means a person to whom or for whose benefit an insurer makes a
633 promise in an insurance policy and includes:

634 (i) a policyholder;
635 (ii) a subscriber;
636 (iii) a member; and
637 (iv) a beneficiary.
638 (b) The definition in Subsection (89)(a):
639 (i) applies only to this title; and
640 (ii) does not define the meaning of this word as used in an insurance policy or
641 certificate.
642 (90) (a) (i) "Insurer" means a person doing an insurance business as a principal
643 including:
644 (A) a fraternal benefit society;
645 (B) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-
646 1305(2) and (3);
647 (C) a motor club;
648 (D) an employee welfare plan; and
649 (E) a person purporting or intending to do an insurance business as a principal on that
650 person's own account.
651 (ii) "Insurer" does not include a governmental entity to the extent the governmental
652 entity is engaged in an activity described in Section 31A-12-107.
653 (b) "Admitted insurer" is defined in Subsection (163)(b).
654 (c) "Alien insurer" is defined in Subsection (7).
655 (d) "Authorized insurer" is defined in Subsection (163)(b).
656 (e) "Domestic insurer" is defined in Subsection (48).
657 (f) "Foreign insurer" is defined in Subsection (65).
658 (g) "Nonadmitted insurer" is defined in Subsection (163)(a).
659 (h) "Unauthorized insurer" is defined in Subsection (163)(a).
660 (91) "Interinsurance exchange" is defined in Subsection (142).
661 (92) "Involuntary unemployment insurance" means insurance:
662 (a) offered in connection with an extension of credit; and
663 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
664 coming due on a:
665 (i) specific loan; or
666 (ii) credit transaction.
667 (93) "Large employer," in connection with a health benefit plan, means an employer

*** PROTECTED ***

668 who, with respect to a calendar year and to a plan year:

669 (a) employed an average of at least 51 eligible employees on each business day during
670 the preceding calendar year; and

671 (b) employs at least two employees on the first day of the plan year.

672 (94) "Late enrollee," with respect to an employer health benefit plan, means an
673 individual whose enrollment is a late enrollment.

674 (95) "Late enrollment," with respect to an employer health benefit plan, means
675 enrollment of an individual other than:

676 (a) on the earliest date on which coverage can become effective for the individual
677 under the terms of the plan; or

678 (b) through special enrollment.

679 (96) (a) Except for a retainer contract or legal assistance described in Section 31A-1-
680 103, "legal expense insurance" means insurance written to indemnify or pay for a specified
681 legal expense.

682 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
683 expectation of an enforceable right.

684 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
685 legal services incidental to other insurance coverage.

686 (97) (a) "Liability insurance" means insurance against liability:

687 (i) for death, injury, or disability of a human being, or for damage to property,
688 exclusive of the coverages under:

689 (A) Subsection (107) for medical malpractice insurance;

690 (B) Subsection (134) for professional liability insurance; and

691 (C) Subsection (168) for workers' compensation insurance;

692 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
693 insured who is injured, irrespective of legal liability of the insured, when issued with or
694 supplemental to insurance against legal liability for the death, injury, or disability of a human
695 being, exclusive of the coverages under:

696 (A) Subsection (107) for medical malpractice insurance;

697 (B) Subsection (134) for professional liability insurance; and
698 (C) Subsection (168) for workers' compensation insurance;
699 (iii) for loss or damage to property resulting from an accident to or explosion of a
700 boiler, pipe, pressure container, machinery, or apparatus;
701 (iv) for loss or damage to property caused by:
702 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
703 (B) water entering through a leak or opening in a building; or
704 (v) for other loss or damage properly the subject of insurance not within another kind
705 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
706 (b) "Liability insurance" includes:
707 (i) vehicle liability insurance as defined in Subsection (165);
708 (ii) residential dwelling liability insurance as defined in Subsection (145); and
709 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
710 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
711 elevator, boiler, machinery, or apparatus.
712 (98) (a) "License" means the authorization issued by the commissioner to engage in an
713 activity that is part of or related to the insurance business.
714 (b) "License" includes a certificate of authority issued to an insurer.
715 (99) (a) "Life insurance" means:
716 (i) insurance on a human life; and
717 (ii) insurance pertaining to or connected with human life.
718 (b) The business of life insurance includes:
719 (i) granting a death benefit;
720 (ii) granting an annuity benefit;
721 (iii) granting an endowment benefit;
722 (iv) granting an additional benefit in the event of death by accident;
723 (v) granting an additional benefit to safeguard the policy against lapse; and
724 (vi) providing an optional method of settlement of proceeds.
725 (100) "Limited license" means a license that:
726 (a) is issued for a specific product of insurance; and
727 (b) limits an individual or agency to transact only for that product or insurance.
728 (101) "Limited line credit insurance" includes the following forms of insurance:
729 (a) credit life;
730 (b) credit accident and health;

731 (c) credit property;
732 (d) credit unemployment;
733 (e) involuntary unemployment;
734 (f) mortgage life;
735 (g) mortgage guaranty;
736 (h) mortgage accident and health;
737 (i) guaranteed automobile protection; and
738 (j) another form of insurance offered in connection with an extension of credit that:
739 (i) is limited to partially or wholly extinguishing the credit obligation; and
740 (ii) the commissioner determines by rule should be designated as a form of limited line
741 credit insurance.

742 (102) "Limited line credit insurance producer" means a person who sells, solicits, or
743 negotiates one or more forms of limited line credit insurance coverage to an individual through
744 a master, corporate, group, or individual policy.

745 (103) "Limited line insurance" includes:

746 (a) bail bond;
747 (b) limited line credit insurance;
748 (c) legal expense insurance;
749 (d) motor club insurance;
750 (e) rental car-related insurance;
751 (f) travel insurance; and
752 (g) another form of limited insurance that the commissioner determines by rule should
753 be designated a form of limited line insurance.

754 (104) "Limited lines authority" includes:

755 (a) the lines of insurance listed in Subsection (103); and
756 (b) a customer service representative.

757 (105) "Limited lines producer" means a person who sells, solicits, or negotiates limited
758 lines insurance.

759 (106) (a) "Long-term care insurance" means an insurance policy or rider advertised,
760 marketed, offered, or designated to provide coverage:

761 (i) in a setting other than an acute care unit of a hospital;
762 (ii) for not less than 12 consecutive months for a covered person on the basis of:
763 (A) expenses incurred;
764 (B) indemnity;

765 (C) prepayment; or
766 (D) another method;
767 (iii) for one or more necessary or medically necessary services that are:
768 (A) diagnostic;
769 (B) preventative;
770 (C) therapeutic;
771 (D) rehabilitative;
772 (E) maintenance; or
773 (F) personal care; and
774 (iv) that may be issued by:
775 (A) an insurer;
776 (B) a fraternal benefit society;
777 (C) (I) a nonprofit health hospital; and
778 (II) a medical service corporation;
779 (D) a prepaid health plan;
780 (E) a health maintenance organization; or
781 (F) an entity similar to the entities described in Subsections (106)(a)(iv)(A) through
782 (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.
783 (b) "Long-term care insurance" includes:
784 (i) any of the following that provide directly or supplement long-term care insurance:
785 (A) a group or individual annuity or rider; or
786 (B) a life insurance policy or rider;
787 (ii) a policy or rider that provides for payment of benefits on the basis of:
788 (A) cognitive impairment; or
789 (B) functional capacity; or
790 (iii) a qualified long-term care insurance contract.
791 (c) "Long-term care insurance" does not include:
792 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
793 (ii) basic hospital expense coverage;
794 (iii) basic medical/surgical expense coverage;
795 (iv) hospital confinement indemnity coverage;
796 (v) major medical expense coverage;
797 (vi) income replacement or related asset-protection coverage;
798 (vii) accident only coverage;

799 (viii) coverage for a specified:
800 (A) disease; or
801 (B) accident;
802 (ix) limited benefit health coverage; or
803 (x) a life insurance policy that accelerates the death benefit to provide the option of a
804 lump sum payment:
805 (A) if the following are not conditioned on the receipt of long-term care:
806 (I) benefits; or
807 (II) eligibility; and
808 (B) the coverage is for one or more the following qualifying events:
809 (I) terminal illness;
810 (II) medical conditions requiring extraordinary medical intervention; or
811 (III) permanent institutional confinement.
812 (107) "Medical malpractice insurance" means insurance against legal liability incident
813 to the practice and provision of a medical service other than the practice and provision of a
814 dental service.
815 (108) "Member" means a person having membership rights in an insurance
816 corporation.
817 (109) "Minimum capital" or "minimum required capital" means the capital that must
818 be constantly maintained by a stock insurance corporation as required by statute.
819 (110) "Mortgage accident and health insurance" means insurance offered in connection
820 with an extension of credit that provides indemnity for payments coming due on a mortgage
821 while the debtor is disabled.
822 (111) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
823 or other creditor is indemnified against losses caused by the default of a debtor.
824 (112) "Mortgage life insurance" means insurance on the life of a debtor in connection
825 with an extension of credit that pays if the debtor dies.
826 (113) "Motor club" means a person:
827 (a) licensed under:
828 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
829 (ii) Chapter 11, Motor Clubs; or
830 (iii) Chapter 14, Foreign Insurers; and
831 (b) that promises for an advance consideration to provide for a stated period of time
832 one or more:

833 (i) legal services under Subsection 31A-11-102(1)(b);
834 (ii) bail services under Subsection 31A-11-102(1)(c); or
835 (iii) (A) trip reimbursement;
836 (B) towing services;
837 (C) emergency road services;
838 (D) stolen automobile services;
839 (E) a combination of the services listed in Subsections (113)(b)(iii)(A) through (D); or
840 (F) other services given in Subsections 31A-11-102(1)(b) through (f).
841 (114) "Mutual" means a mutual insurance corporation.
842 (115) "Network plan" means health care insurance:
843 (a) that is issued by an insurer; and
844 (b) under which the financing and delivery of medical care is provided, in whole or in
845 part, through a defined set of providers under contract with the insurer, including the financing
846 and delivery of an item paid for as medical care.
847 (116) "Nonparticipating" means a plan of insurance under which the insured is not
848 entitled to receive a dividend representing a share of the surplus of the insurer.
849 (117) "Ocean marine insurance" means insurance against loss of or damage to:
850 (a) ships or hulls of ships;
851 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys,
852 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
853 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
854 (c) earnings such as freight, passage money, commissions, or profits derived from
855 transporting goods or people upon or across the oceans or inland waterways; or
856 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
857 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
858 in connection with maritime activity.
859 (118) "Order" means an order of the commissioner.
860 (119) "Outline of coverage" means a summary that explains an accident and health
861 insurance policy.
862 (120) "Participating" means a plan of insurance under which the insured is entitled to
863 receive a dividend representing a share of the surplus of the insurer.
864 (121) "Participation," as used in a health benefit plan, means a requirement relating to
865 the minimum percentage of eligible employees that must be enrolled in relation to the total
866 number of eligible employees of an employer reduced by each eligible employee who

*** PROTECTED ***

867 voluntarily declines coverage under the plan because the employee:

868 (a) has other group health care insurance coverage; or

869 (b) receives:

870 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social

871 Security Amendments of 1965; or

872 (ii) another government health benefit.

873 (122) "Person" includes:

874 (a) an individual;

875 (b) a partnership;

876 (c) a corporation;

877 (d) an incorporated or unincorporated association;

878 (e) a joint stock company;

879 (f) a trust;

880 (g) a limited liability company;

881 (h) a reciprocal;

882 (i) a syndicate; or

883 (j) another similar entity or combination of entities acting in concert.

884 (123) "Personal lines insurance" means property and casualty insurance coverage sold

885 for primarily noncommercial purposes to:

886 (a) an individual; or

887 (b) a family.

888 (124) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

889 (125) "Plan year" means:

890 (a) the year that is designated as the plan year in:

891 (i) the plan document of a group health plan; or

892 (ii) a summary plan description of a group health plan;

893 (b) if the plan document or summary plan description does not designate a plan year or

894 there is no plan document or summary plan description:

895 (i) the year used to determine deductibles or limits;

896 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
897 or
898 (iii) the employer's taxable year if:
899 (A) the plan does not impose deductibles or limits on a yearly basis; and
900 (B) (I) the plan is not insured; or
901 (II) the insurance policy is not renewed on an annual basis; or
902 (c) in a case not described in Subsection (125)(a) or (b), the calendar year.
903 (126) (a) "Policy" means a document, including any attached endorsement or
904 application that:
905 (i) purports to be an enforceable contract; and
906 (ii) memorializes in writing some or all of the terms of an insurance contract.
907 (b) "Policy" includes a service contract issued by:
908 (i) a motor club under Chapter 11, Motor Clubs;
909 (ii) a service contract provided under Chapter 6a, Service Contracts; and
910 (iii) a corporation licensed under:
911 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
912 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
913 (c) "Policy" does not include:
914 (i) a certificate under a group insurance contract; or
915 (ii) a document that does not purport to have legal effect.
916 (127) "Policyholder" means the person who controls a policy, binder, or oral contract
917 by ownership, premium payment, or otherwise.
918 (128) "Policy illustration" means a presentation or depiction that includes
919 nonguaranteed elements of a policy of life insurance over a period of years.
920 (129) "Policy summary" means a synopsis describing the elements of a life insurance
921 policy.
922 (130) "Preexisting condition," with respect to a health benefit plan:
923 (a) means a condition that was present before the effective date of coverage, whether
924 or not medical advice, diagnosis, care, or treatment was recommended or received before that
925 day; and
926 (b) does not include a condition indicated by genetic information unless an actual
927 diagnosis of the condition by a physician has been made.
928 (131) (a) "Premium" means the monetary consideration for an insurance policy.
929 (b) "Premium" includes, however designated:

930 (i) an assessment;

931 (ii) a membership fee;

932 (iii) a required contribution; or

933 (iv) monetary consideration.

934 (c) (i) "Premium" does not include consideration paid to a third party administrator for

935 the third party administrator's services.

936 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for

937 insurance on the risks administered by the third party administrator.

938 (132) "Principal officers" of a corporation means the officers designated under

939 Subsection 31A-5-203(3).

940 (133) "Proceeding" includes an action or special statutory proceeding.

941 (134) "Professional liability insurance" means insurance against legal liability incident

942 to the practice of a profession and provision of a professional service.

943 (135) (a) Except as provided in Subsection (135)(b), "property insurance" means

944 insurance against loss or damage to real or personal property of every kind and any interest in

945 that property:

946 (i) from all hazards or causes; and

947 (ii) against loss consequential upon the loss or damage including vehicle

948 comprehensive and vehicle physical damage coverages.

949 (b) "Property insurance" does not include:

950 (i) inland marine insurance as defined in Subsection (81); and

951 (ii) ocean marine insurance as defined under Subsection (117).

952 (136) "Qualified long-term care insurance contract" or "federally tax qualified long-

953 term care insurance contract" means:

954 (a) an individual or group insurance contract that meets the requirements of Section

955 7702B(b), Internal Revenue Code; or

956 (b) the portion of a life insurance contract that provides long-term care insurance:

957 (i) (A) by rider; or

958 (B) as a part of the contract; and

959 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue

960 Code.

961 (137) "Qualified United States financial institution" means an institution that:

962 (a) is:

963 (i) organized under the laws of the United States or any state; or

964 (ii) in the case of a United States office of a foreign banking organization, licensed
965 under the laws of the United States or any state;

966 (b) is regulated, supervised, and examined by a United States federal or state authority
967 having regulatory authority over a bank or trust company; and

968 (c) meets the standards of financial condition and standing that are considered
969 necessary and appropriate to regulate the quality of a financial institution whose letters of
970 credit will be acceptable to the commissioner as determined by:

971 (i) the commissioner by rule; or

972 (ii) the Securities Valuation Office of the National Association of Insurance
973 Commissioners.

974 (138) (a) "Rate" means:

975 (i) the cost of a given unit of insurance; or

976 (ii) for property-casualty insurance, that cost of insurance per exposure unit either
977 expressed as:

978 (A) a single number; or

979 (B) a pure premium rate, adjusted before the application of individual risk variations
980 based on loss or expense considerations to account for the treatment of:

981 (I) expenses;

982 (II) profit; and

983 (III) individual insurer variation in loss experience.

984 (b) "Rate" does not include a minimum premium.

985 (139) (a) Except as provided in Subsection (139)(b), "rate service organization" means
986 a person who assists an insurer in rate making or filing by:

987 (i) collecting, compiling, and furnishing loss or expense statistics;

988 (ii) recommending, making, or filing rates or supplementary rate information; or

989 (iii) advising about rate questions, except as an attorney giving legal advice.

990 (b) "Rate service organization" does not mean:

991 (i) an employee of an insurer;

992 (ii) a single insurer or group of insurers under common control;

993 (iii) a joint underwriting group; or

994 (iv) a natural person serving as an actuarial or legal consultant.

995 (140) "Rating manual" means any of the following used to determine initial and
996 renewal policy premiums:

997 (a) a manual of rates;

998 (b) a classification;
999 (c) a rate-related underwriting rule; and
1000 (d) a rating formula that describes steps, policies, and procedures for determining
1001 initial and renewal policy premiums.

1002 (141) "Received by the department" means:
1003 (a) except as provided in Subsection (141)(b), the date delivered to and stamped
1004 received by the department, whether delivered:
1005 (i) in person; or
1006 (ii) electronically; and
1007 (b) if delivered to the department by a delivery service, the delivery service's postmark
1008 date or pick-up date unless otherwise stated in:
1009 (i) statute;
1010 (ii) rule; or
1011 (iii) a specific filing order.

1012 (142) "Reciprocal" or "interinsurance exchange" means an unincorporated association
1013 of persons:
1014 (a) operating through an attorney-in-fact common to all of the persons; and
1015 (b) exchanging insurance contracts with one another that provide insurance coverage
1016 on each other.

1017 (143) "Reinsurance" means an insurance transaction where an insurer, for
1018 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1019 reinsurance transactions, this title sometimes refers to:
1020 (a) the insurer transferring the risk as the "ceding insurer"; and
1021 (b) the insurer assuming the risk as the:
1022 (i) "assuming insurer"; or
1023 (ii) "assuming reinsurer."

1024 (144) "Reinsurer" means a person licensed in this state as an insurer with the authority
1025 to assume reinsurance.

1026 (145) "Residential dwelling liability insurance" means insurance against liability
1027 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that
1028 is a detached single family residence or multifamily residence up to four units.

1029 (146) (a) "Retrocession" means reinsurance with another insurer of a liability assumed
1030 under a reinsurance contract.
1031 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a

*** PROTECTED ***

- 1032 liability assumed under a reinsurance contract.
- 1033 (147) "Rider" means an endorsement to:
- 1034 (a) an insurance policy; or
- 1035 (b) an insurance certificate.
- 1036 (148) (a) "Security" means a:
- 1037 (i) note;
- 1038 (ii) stock;
- 1039 (iii) bond;
- 1040 (iv) debenture;
- 1041 (v) evidence of indebtedness;
- 1042 (vi) certificate of interest or participation in a profit-sharing agreement;
- 1043 (vii) collateral-trust certificate;
- 1044 (viii) preorganization certificate or subscription;
- 1045 (ix) transferable share;
- 1046 (x) investment contract;
- 1047 (xi) voting trust certificate;
- 1048 (xii) certificate of deposit for a security;
- 1049 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 1050 payments out of production under such a title or lease;
- 1051 (xiv) commodity contract or commodity option;
- 1052 (xv) certificate of interest or participation in, temporary or interim certificate for,
- 1053 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 1054 in Subsections (148)(a)(i) through (xiv); or
- 1055 (xvi) another interest or instrument commonly known as a security.
- 1056 (b) "Security" does not include:
- 1057 (i) any of the following under which an insurance company promises to pay money in
- 1058 a specific lump sum or periodically for life or some other specified period:
- 1059 (A) insurance;
- 1060 (B) endowment policy; or
- 1061 (C) annuity contract; or
- 1062 (ii) a burial certificate or burial contract.
- 1063 (149) "Secondary medical condition" means a complication related to an exclusion

*** PROTECTED ***

1064 from coverage in accident and health insurance.

1065 (150) "Self-insurance" means an arrangement under which a person provides for
1066 spreading its own risks by a systematic plan.

1067 (a) Except as provided in this Subsection (150), "self-insurance" does not include an
1068 arrangement under which a number of persons spread their risks among themselves.

1069 (b) "Self-insurance" includes:

1070 (i) an arrangement by which a governmental entity undertakes to indemnify an
1071 employee for liability arising out of the employee's employment; and

1072 (ii) an arrangement by which a person with a managed program of self-insurance and
1073 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
1074 employees for liability or risk which is related to the relationship or employment.

1075 (c) "Self-insurance" does not include an arrangement with an independent contractor.

1076 (151) "Sell" means to exchange a contract of insurance:

1077 (a) by any means;

1078 (b) for money or its equivalent; and

1079 (c) on behalf of an insurance company.

1080 (152) "Short-term care insurance" means an insurance policy or rider advertised,
1081 marketed, offered, or designed to provide coverage that is similar to long-term care insurance,
1082 but that provides coverage for less than 12 consecutive months for each covered person.

1083 (153) "Significant break in coverage" means a period of 63 consecutive days during
1084 each of which an individual does not have creditable coverage.

1085 (154) "Small employer," in connection with a health benefit plan, means an employer
1086 who, with respect to a calendar year and to a plan year:

1087 (a) (i) employed an average of at least two employees but not more than 50 eligible
1088 employees on each business day during the preceding calendar year; and

1089 ~~[(b)]~~ (ii) employs at least two employees on the first day of the plan year[-]; or

1090 (b) beginning January 1, 2010, is an individual who:

1091 (i) has a license to conduct business in the state; and

1092 (ii) (A) if the individual operated the business during the previous taxable year, can

*** PROTECTED ***

1093 demonstrate that for the previous taxable year, at least 50% of the adjusted gross income, as
1094 defined in Section 59-10-103, for the individual's total household came from the business for
1095 which the individual has a license; or

1096 (B) if the individual did not operate the business during the previous taxable year, can
1097 demonstrate on the first day of the plan year, that at least 50% of the adjusted gross income, as
1098 defined in Section 59-10-103, for the individual's total household comes from the business for
1099 which the individual has a license.

1100 (155) "Special enrollment period," in connection with a health benefit plan, has the
1101 same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1102 Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

1103 (156) (a) "Subsidiary" of a person means an affiliate controlled by that person either
1104 directly or indirectly through one or more affiliates or intermediaries.

1105 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1106 shares are owned by that person either alone or with its affiliates, except for the minimum
1107 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1108 others.

1109 (157) Subject to Subsection (83)(b), "surety insurance" includes:

1110 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1111 perform the principal's obligations to a creditor or other obligee;

1112 (b) bail bond insurance; and

1113 (c) fidelity insurance.

1114 (158) (a) "Surplus" means the excess of assets over the sum of paid-in capital and
1115 liabilities.

1116 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that is designated by
1117 the insurer as permanent.

1118 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require
1119 that mutuals doing business in this state maintain specified minimum levels of permanent
1120 surplus.

1121 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is
1122 essentially the same as the minimum required capital requirement that applies to stock insurers.

1123 (c) "Excess surplus" means:

1124 (i) for a life insurer, accident and health insurer, health organization, or property and

*** PROTECTED ***

1125 casualty insurer as defined in Section 31A-17-601, the lesser of:
1126 (A) that amount of an insurer's or health organization's total adjusted capital, as defined
1127 in Subsection (161), that exceeds the product of:
1128 (I) 2.5; and
1129 (II) the sum of the insurer's or health organization's minimum capital or permanent
1130 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1131 (B) that amount of an insurer's or health organization's total adjusted capital, as defined
1132 in Subsection (161), that exceeds the product of:
1133 (I) 3.0; and
1134 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1135 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title
1136 insurer that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1137 (A) 1.5; and
1138 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1139 (159) "Third party administrator" or "administrator" means a person who collects
1140 charges or premiums from, or who, for consideration, adjusts or settles claims of residents of
1141 the state in connection with insurance coverage, annuities, or service insurance coverage,
1142 except:
1143 (a) a union on behalf of its members;
1144 (b) a person administering a:
1145 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1146 1974;
1147 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1148 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1149 (c) an employer on behalf of the employer's employees or the employees of one or
1150 more of the subsidiary or affiliated corporations of the employer;
1151 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance
1152 for which the insurer holds a license in this state; or
1153 (e) a person:

1154 (i) licensed or exempt from licensing under:
1155 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1156 Reinsurance Intermediaries; or
1157 (B) Chapter 26, Insurance Adjusters; and
1158 (ii) whose activities are limited to those authorized under the license the person holds
1159 or for which the person is exempt.

1160 (160) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner
1161 of real or personal property or the holder of liens or encumbrances on that property, or others
1162 interested in the property against loss or damage suffered by reason of liens or encumbrances
1163 upon, defects in, or the unmarketability of the title to the property, or invalidity or
1164 unenforceability of any liens or encumbrances on the property.

1165 (161) "Total adjusted capital" means the sum of an insurer's or health organization's
1166 statutory capital and surplus as determined in accordance with:
1167 (a) the statutory accounting applicable to the annual financial statements required to be
1168 filed under Section 31A-4-113; and
1169 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1170 Section 31A-17-601.

1171 (162) (a) "Trustee" means "director" when referring to the board of directors of a
1172 corporation.
1173 (b) "Trustee," when used in reference to an employee welfare fund, means an
1174 individual, firm, association, organization, joint stock company, or corporation, whether acting
1175 individually or jointly and whether designated by that name or any other, that is charged with
1176 or has the overall management of an employee welfare fund.

1177 (163) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"
1178 means an insurer:
1179 (i) not holding a valid certificate of authority to do an insurance business in this state;
1180 or
1181 (ii) transacting business not authorized by a valid certificate.

1182 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1183 (i) holding a valid certificate of authority to do an insurance business in this state; and
1184 (ii) transacting business as authorized by a valid certificate.

1185 (164) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

1186 (165) "Vehicle liability insurance" means insurance against liability resulting from or
1187 incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle

*** PROTECTED ***

1188 comprehensive or vehicle physical damage coverage under Subsection (135).

1189 (166) "Voting security" means a security with voting rights, and includes a security
1190 convertible into a security with a voting right associated with the security.

1191 (167) "Waiting period" for a health benefit plan means the period that must pass before
1192 coverage for an individual, who is otherwise eligible to enroll under the terms of the health
1193 benefit plan, can become effective.

1194 (168) "Workers' compensation insurance" means:

1195 (a) insurance for indemnification of an employer against liability for compensation
1196 based on:

1197 (i) a compensable accidental injury; and

1198 (ii) occupational disease disability;

1199 (b) employer's liability insurance incidental to workers' compensation insurance and
1200 written in connection with workers' compensation insurance; and

1201 (c) insurance assuring to a person entitled to workers' compensation benefits the
1202 compensation provided by law.

1203 Section 2. Section **31A-8-501** is amended to read:

1204 **31A-8-501. Access to health care providers.**

1205 (1) As used in this section:

1206 (a) "Class of health care provider" means a health care provider or a health care facility
1207 regulated by the state within the same professional, trade, occupational, or certification
1208 category established under Title 58, Occupations and Professions, or within the same facility
1209 licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and
1210 Inspection Act.

1211 (b) "Covered health care services" or "covered services" means health care services for
1212 which an enrollee is entitled to receive under the terms of a health maintenance organization
1213 contract.

1214 (c) "Credentialed staff member" means a health care provider with active staff
1215 privileges at an independent hospital or federally qualified health center.

1216 (d) "Federally qualified health center" means as defined in the Social Security Act, 42

*** PROTECTED ***

1217 U.S.C. Sec. 1395x.

1218 (e) "Independent hospital" means a general acute hospital or a critical access hospital
1219 that:

1220 (i) is either:

1221 (A) located 20 miles or more from any other general acute hospital or critical access
1222 hospital; or

1223 (B) licensed as of January 1, 2004;

1224 (ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and
1225 Inspection Act; and

1226 (iii) is controlled by a board of directors of which 51% or more reside in the county
1227 where the hospital is located and:

1228 (A) the board of directors is ultimately responsible for the policy and financial
1229 decisions of the hospital; or

1230 (B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part,
1231 by an entity that owns or controls a health maintenance organization if the hospital is a
1232 contracting facility of the organization.

1233 (f) "Noncontracting provider" means an independent hospital, federally qualified
1234 health center, or credentialed staff member who has not contracted with a health maintenance
1235 organization to provide health care services to enrollees of the organization.

1236 (2) Except for a health maintenance organization which is under the common
1237 ownership or control of an entity with a hospital located within ten paved road miles of an
1238 independent hospital, a health maintenance organization shall pay for covered health care
1239 services rendered to an enrollee by an independent hospital, a credentialed staff member at an
1240 independent hospital, or a credentialed staff member at his local practice location if:

1241 (a) the enrollee:

1242 (i) lives or resides within 30 paved road miles of the independent hospital; or

1243 (ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the
1244 independent hospital than a contracting hospital;

1245 (b) the independent hospital is located prior to December 31, 2000 in a county with a
1246 population density of less than 100 people per square mile, or the independent hospital is
1247 located in a county with a population density of less than 30 people per square mile; and

1248 (c) the enrollee has complied with the prior authorization and utilization review

*** PROTECTED ***

1249 requirements otherwise required by the health maintenance organization contract.

1250 (3) A health maintenance organization shall pay for covered health care services
1251 rendered to an enrollee at a federally qualified health center if:

1252 (a) the enrollee:

1253 (i) lives or resides within 30 paved road miles of the federally qualified health center;

1254 or

1255 (ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the
1256 federally qualified health center than a contracting provider;

1257 (b) the federally qualified health center is located in a county with a population density
1258 of less than 30 people per square mile; and

1259 (c) the enrollee has complied with the prior authorization and utilization review
1260 requirements otherwise required by the health maintenance organization contract.

1261 (4) (a) A health maintenance organization shall reimburse a noncontracting provider or
1262 the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it
1263 pays to contracting providers under a noncapitated arrangement for comparable services.

1264 (b) A health maintenance organization shall reimburse a federally qualified health
1265 center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as
1266 paid by the health maintenance organization under a noncapitated arrangement for comparable
1267 services to a contracting provider in the same class of health care providers as the provider who
1268 rendered the service.

1269 (5) (a) A non-contracting independent hospital may not balance bill a patient when the
1270 health maintenance organization reimburses a non-contracting independent hospital or an
1271 enrollee in accordance with Subsection (4)(a).

1272 (b) A non-contracting federally qualified health center may not balance bill a patient
1273 when the federally qualified health center or the enrollee receives reimbursement in accordance
1274 with Subsection (4)(b).

1275 [~~5~~] (6) A noncontracting provider may only refer an enrollee to another
1276 noncontracting provider so as to obligate the enrollee's health maintenance organization to pay
1277 for the resulting services if:

1278 (a) the noncontracting provider making the referral or the enrollee has received prior
1279 authorization from the organization for the referral; or

1280 (b) the practice location of the noncontracting provider to whom the referral is made:

1281 (i) is located in a county with a population density of less than 25 people per square
1282 mile; and

1283 (ii) is within 30 paved road miles of:

1284 (A) the place where the enrollee lives or resides; or

1285 (B) the independent hospital or federally qualified health center at which the enrollee
1286 may receive covered services pursuant to Subsection (2) or (3).

1287 ~~[(6)]~~ (7) Notwithstanding this section, a health maintenance organization may contract
1288 directly with an independent hospital, federally qualified health center, or credentialed staff
1289 member.

1290 ~~[(7)]~~ (8) (a) A health maintenance organization that violates any provision of this
1291 section is subject to sanctions as determined by the commissioner in accordance with Section
1292 31A-2-308.

1293 (b) Violations of this section include:

1294 (i) failing to provide the notice required by Subsection ~~[(7)]~~ (8)(d) by placing the
1295 notice in any health maintenance organization's provider list that is supplied to enrollees,
1296 including any website maintained by the health maintenance organization;

1297 (ii) failing to provide notice of an enrollee's rights under this section when:

1298 (A) an enrollee makes personal contact with the health maintenance organization by
1299 telephone, electronic transaction, or in person; and

1300 (B) the enrollee inquires about his rights to access an independent hospital or federally
1301 qualified health center; and

1302 (iii) refusing to reprocess or reconsider a claim, initially denied by the health
1303 maintenance organization, when the provisions of this section apply to the claim.

1304 (c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of
1305 Commissioner:

1306 (i) adopt rules as necessary to implement this section;

1307 (ii) identify in rule:

1308 (A) the counties with a population density of less than 100 people per square mile;

1309 (B) independent hospitals as defined in Subsection (1)(e); and

1310 (C) federally qualified health centers as defined in Subsection (1)(d).

1311 (d) (i) A health maintenance organization shall:

1312 (A) use the information developed by the commissioner under Subsection ~~(7)~~ (8)(c)
1313 to identify the rural counties, independent hospitals, and federally qualified health centers that
1314 are located in the health maintenance organization's service area; and

1315 (B) include the providers identified under Subsection ~~(7)~~ (8)(d)(i)(A) in the notice
1316 required in Subsection ~~(7)~~ (8)(d)(ii).

1317 (ii) The health maintenance organization shall provide the following notice, in bold
1318 type, to enrollees as specified under Subsection ~~(7)~~ (8)(b)(i), and shall keep the notice
1319 current:

1320 "You may be entitled to coverage for health care services from the following non-HMO
1321 contracted providers if you live or reside within 30 paved road miles of the listed providers, or
1322 if you live or reside in closer proximity to the listed providers than to your HMO contracted
1323 providers:

1324 This list may change periodically, please check on our website or call for verification.
1325 Please be advised that if you choose a ~~noncontracted~~ non-contracted provider you will be
1326 responsible for any charges not covered by your health insurance plan.

1327 If you have questions concerning your rights to see a provider on this list you may
1328 contact your health maintenance organization at _____. If the HMO does not resolve your
1329 problem, you may contact the Office of Consumer Health Assistance in the Insurance
1330 Department, toll free." The phone number for the Office of Consumer Health Assistance (OCHA) is often
1331 hard to find. It would be helpful to add concrete ways to better promote OCHA, for example through the portal,
1332 the internet, etc.

1333 (e) A person whose interests are affected by an alleged violation of this section may
1334 contact the Office of Consumer Health Assistance and request assistance, or file a complaint as
1335 provided in Section 31A-2-216.

1336 Section 3. Section **31A-22-613.5** is amended to read:

1337 **31A-22-613.5. Price and value comparisons of health insurance -- Basic Health**
1338 **Care Plan.**

1339 (1) (a) Except as provided in Subsection (1)(b), this section applies to:

1340 (i) all health ~~insurance policies and~~ benefit plans;

1341 (ii) all health maintenance organization contracts[-]; and

1342 ~~[(b) Subsection (3) applies to:]~~

1343 ~~[(i) all health insurance policies and health maintenance organization contracts; and]~~

1344 (iii) coverage offered to state employees under Subsection 49-20-202(1)(a).

1345 ~~[(ii)]~~ (b) Subsections (2)(b) does not apply to coverage offered to state employees

*** PROTECTED ***

1346 under Subsection 49-20-202(1)(a).

1347 (2) ~~The~~ (a) By July 1, 2009, the commissioner shall adopt a Utah NetCare Basic
1348 Health Care Plan consistent with [this section to be offered] Subsection (5).

1349 ~~(b) (i) An insurer shall offer the Basic Health Care Plan described in Subsection (4)~~
1350 ~~through December 31, 2009 under the open enrollment provisions of Chapter 30, Individual,~~
1351 ~~Small Employer, and Group Health Insurance Act.~~

1352 ~~(ii) Beginning January 1, 2010, an insurer shall offer the Utah NetCare Basic Health~~
1353 ~~Care Plan adopted under Subsection (2),~~ under the open enrollment provisions of Chapter 30,
1354 Individual, Small Employer, and Group Health Insurance Act.

1355 (c) Beginning January 1, 2010, an insurer shall offer as a one or 2 year pilot
1356 demonstration the Utah NetCare Basic Health Care Plan developed under Subsection (2) as
1357 alternative coverage under Sections 31A-22-723 and 31A-22-724.

1358 (3) (a) The commissioner shall promote informed consumer behavior and responsible
1359 health insurance and health plans by requiring an insurer ~~issuing health insurance policies or~~
1360 ~~health maintenance organization contracts~~ subject to this section to provide to all enrollees,
1361 prior to enrollment in the health benefit plan or health insurance policy, ~~written~~ disclosure of:

- 1362 (i) the plan designs and options offered by the insurer;
1363 (ii) provider networks available under the insurer's plan designs;
1364 (iii) wellness programs and incentives available under the insurer's plans;
1365 ~~(iv) the rationale and process used to determine approval and denial of claims.~~

1366 ~~(iv)~~ (iv) restrictions or limitations on prescription drugs and biologics including the
1367 use of a formulary and generic substitution;

1368 ~~(v)~~ (v) coverage limits under the plan designs offered by the insurer; ~~and~~

1369 ~~(vi)~~ (vi) any limitation or exclusion of coverage including:

1370 (A) a limitation or exclusion for a secondary medical condition related to a limitation
1371 or exclusion from coverage; and

1372 (B) beginning July 1, 2009, easily understood examples of a limitation or exclusion of
1373 coverage for a secondary medical condition~~[-]~~, including any limitation from coverage for a
1374 secondary medical condition resulting from the use of an excluded drug;

1375 ~~(b) In addition to the requirements of Subsections (3)(a), (d), and (e) an insurer~~
1376 ~~described in Subsection (3)(a) shall file the written disclosure required by this Subsection (3) to~~
1377 ~~the commissioner.]~~

1378 (vii) for each plan design offered by the insurer:
1379 (A) the percentage of claims paid by the insurer within 30 days of the date a claim is
1380 submitted to the insurer; and
1381 (B) the percentage of adverse benefit determinations by the insurer which were
1382 subsequently overturned on independent review under Section 31A-22-629 as a percentage of
1383 total claims paid by the insurer; and
1384 (viii) the department's rating of the insurer's solvency based on methodology
1385 established by the department by administrative rule.
1386 (C) the medical loss ratio”, which should then be defined (for example: “In principle,
1387 this statistic measures the fraction of total premium revenue that health plans devote to clinical
1388 services, as distinct from administration and profit.” Health Affairs, 2007.
1389 <http://content.healthaffairs.org/cgi/reprint/16/4/176.pdf>).
1390 (b) The commissioner shall adopt administrative rules in accordance with Title 63G,
1391 Chapter 3, Utah Administrative Rulemaking Act , and Section 31A-22-614.5, to implement
1392 standards for the electronic submission of the information required by this section. The
1393 administrative rules may require that the information be transmitted by the insurer to the
1394 department:
1395 (i) upon commencement of operations in the state; and
1396 (ii) anytime the insurer amends ~~[any of the following]~~ the items described in
1397 Subsection (3)(a)[?].
1398 ~~[(A) treatment policies;]~~
1399 ~~[(B) practice standards;]~~
1400 ~~[(C) restrictions;]~~
1401 ~~[(D) coverage limits of the insurer's health benefit plan or health insurance policy; or]~~
1402 ~~[(E) limitations or exclusions of coverage including a limitation or exclusion for a~~
1403 ~~secondary medical condition related to a limitation or exclusion of the insurer's health~~
1404 ~~insurance plan.]~~
1405 ~~[(e) The commissioner may adopt rules to implement the disclosure requirements of~~
1406 ~~this Subsection (3), taking into account:]~~
1407 ~~[(i) business confidentiality of the insurer;]~~
1408 ~~[(ii) definitions of terms;]~~
1409 ~~[(iii) the method of disclosure to enrollees; and]~~
1410 ~~[(iv) limitations and exclusions.]~~
1411 ~~[(d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available~~

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1412 ~~to prospective enrollees and maintain evidence of the fact of the disclosure of:]~~
 1413 ~~[(i) the drugs included;]~~
 1414 ~~[(ii) the patented drugs not included;]~~
 1415 ~~[(iii) any conditions that exist as a precedent to coverage; and]~~
 1416 ~~[(iv) any exclusion from coverage for secondary medical conditions that may result~~
 1417 ~~from the use of an excluded drug.]~~
 1418 ~~[(e) Before December 1, 2008, insurers subject to this Subsection (3) shall report to the~~
 1419 ~~Legislature's Health and Human Services Interim Committee and Business and Labor Interim~~
 1420 ~~Committee, either collectively or independently regarding insurer efforts to inform enrollees of~~
 1421 ~~any limitation of coverage or exclusion for a secondary medical condition when an enrollee, or~~
 1422 ~~someone on the enrollee's behalf, contacts the insurer for pre-authorization of a procedure or~~
 1423 ~~use of a drug that is excluded or limited from coverage.]~~
 1424 ~~[(f) (i)] (c)~~ The department shall develop examples of limitations or exclusions of a
 1425 secondary medical condition that an insurer may use under Subsection (3)(a)~~[(iii). (ii)~~
 1426 ~~Examples]. The examples~~ of a limitation or exclusion of coverage provided ~~[under Subsection~~
 1427 ~~(3)(a)(iii) or otherwise]~~ are for illustrative purposes only, and the failure of a particular fact
 1428 situation to fall within the description of an example does not, by itself, support a finding of
 1429 coverage.
 1430 (4) The Basic Health Care Plan ~~[adopted by the commissioner under this section]~~ an
 1431 insurer must offer under the provisions of Subsection (2)(b)(i) shall provide for:
 1432 (a) a lifetime maximum benefit per person not to exceed \$1,000,000;
 1433 (b) an annual maximum benefit per person not less than \$250,000;
 1434 (c) an out-of-pocket maximum of cost-sharing features:
 1435 (i) including:
 1436 (A) a deductible;
 1437 (B) a copayment; and
 1438 (C) coinsurance;
 1439 (ii) not to exceed \$5,000 per person; and
 1440 (iii) for family coverage, not to exceed three times the per person out-of-pocket
 1441 maximum provided in Subsection (4)(c)(ii);
 1442 (d) in relation to its cost-sharing features:
 1443 (i) a deductible of:

1444 (A) not less than \$1,500 per person for major medical expenses; and
1445 (B) for family coverage, not to exceed three times the per person deductible for major
1446 medical expenses under Subsection (4)(d)(i)(A); and
1447 (ii) (A) a copayment of not less than:
1448 (I) \$25 per visit for office services; and
1449 (II) \$150 per visit to an emergency room; or
1450 (B) coinsurance of not less than:
1451 (I) 20% per visit for office services; and
1452 (II) 20% per visit for an emergency room; and
1453 (e) in relation to cost-sharing features for prescription drugs:
1454 (i) (A) a deductible not to exceed \$1,000 per person; and
1455 (B) for family coverage, not to exceed three times the per person deductible provided
1456 in Subsection (4)(e)(i)(A); and
1457 (ii) (A) a copayment of not less than:
1458 (I) the lesser of the cost of the prescription drug or \$15 for the lowest level of cost for
1459 prescription drugs;
1460 (II) the lesser of the cost of the prescription drug or \$25 for the second level of cost for
1461 prescription drugs; and
1462 (III) the lesser of the cost of the prescription drug or \$35 for the highest level of cost
1463 for prescription drugs; or
1464 (B) coinsurance of not less than:
1465 (I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for
1466 prescription drugs;
1467 (II) the lesser of the cost of the prescription drug or 40% for the second level of cost
1468 for prescription drugs; and
1469 (III) the lesser of the cost of the prescription drug or 60% for the highest level of cost
1470 for prescription drugs.
1471 (5) (a) The Utah NetCare Basic Health Care Plans required by Subsection (2)(a) shall
1472 be adopted by the commissioner by administrative rule in accordance with Title 63G, Chapter
1473 3, Utah Administrative Rulemaking Act by July 1, 2009, and shall provide:
1474 (i) healthy lifestyle and wellness incentives; and
1475 (ii) the benefits described in this Subsection (5) or the actuarial equivalent of the
1476 benefits described in this Subsection (5).
1477 (b) The Utah NetCare Basic Health Care Plan benefits may exclude state mandates as

Comment [MSOffice1]: must specify how the wellness incentives will be designed. There is a right way and wrong way to do this. Generally, you only want to reward changes made by the enrollees. You must avoid punishing enrollees for conditions they may be born with or that may be related to socio-economic disadvantages (factors beyond the person's control). Also, as Cathy Dupont's research has shown, people with disabilities will need alternatives for acceptable wellness activities.

*** PROTECTED ***

1478 permitted by Section 31A-22-618.5.

1479 (c) (i) Except as provided in Subsection (5)(c)(ii), the Utah NetCare Basic Health Care
1480 Plan's lifetime maximum benefit per person may not be less than \$1 million.

1481 (ii) The lifetime maximum benefit per person may be not less than \$250,000, if the
1482 Utah NetCare Basic Health Care Plan is an election for alternative COBRA coverage under
1483 Section 31A-22-724.

1484 (d) The Utah NetCare Basic Health Care Plan's annual maximum benefit per person
1485 may not be less than \$250,000.

1486 (e) The Utah NetCare Basic Health Care Plan shall have the following deductibles:

1487 (i) for the low deductible plans:

1488 (A) \$2,000 for an individual plan; and

1489 (B) \$6,000 for a family plan;

1490 (ii) for the high deductible plans:

1491 (A) \$4,000 for an individual plan; and

1492 (B) \$12,000 for a family plan.

1493 (f) The Utah NetCare Basic Health Care Plan shall have the following out-of-pocket
1494 maximum costs, including deductibles, co-pays and co-insurance:

1495 (i) for the low deductible plans:

1496 (A) \$5,000 for an individual plan; and

1497 (B) \$15,000 for a family plan; and

1498 (ii) for the high deductible plan:

1499 (A) \$10,000 for an individual plan; and

1500 (B) \$30,000 for a family plan.

1501 (g) The Utah NetCare Basic Health Care Plan shall provide the following preventive
1502 care benefits before applying any deductible requirements:

1503 (i) all well child exams and immunizations up to age 5, with no annual maximum;

1504 (ii) preventive care up to a \$500 annual maximum;

1505 (iii) primary care, specialist and urgent care up to a \$300 annual maximum; and

1506 (iv) supplemental accident coverage up to a \$500 annual maximum.

1507 (h) The Utah Netcare Basic Health Care Plan shall include the following co-payments
1508 for each exam:

1509 (i) \$15 for preventative care and well child exams;

- 1510 (ii) \$25 for primary care; and
1511 (iii) \$50 for urgent care and specialist care.
1512 (i) The Utah NetCare Basic Health Care Plan shall include a \$200 co-payment for
1513 emergency room visits after applying the deductible.
1514 (j) The Utah NetCare Basic Health Care Plan shall require no less than a 30% co-
1515 insurance after deductible for hospital services, maternity, laboratory work, x-rays, outpatient
1516 surgery services, injectable medications, durable medical equipment, ambulance services, in-
1517 patient mental health services, and out-patient mental health services.
1518 (k) The Utah NetCare Basic Health Care Plan:
1519 (i) shall have the following cost-sharing features for prescription drugs:
1520 (A) a \$15 co-pay for generic drugs; and
1521 (B) 50% co-insurance for name brand drugs; and
1522 (ii) may include formularies and preferred drug lists.

1523 A new section should be added here requiring the *Health System Reform Oversight and Review*
1524 *Committee* report on the impact of all components of the new plan including but not limited to
1525 the number of covered lives, median time an individual or family is enrolled in the policy,
1526 claims experience under the policies, any cost shifting to the private sector for care not covered
1527 under the programs or policies, any impacts on health disparities. Insurers offering NetCare
1528 are required to submit any requested data including but not limited to section ?? (the previous
1529 listed items).

1530 Section 4. Section **31A-22-614.5** is amended to read:

1531 **31A-22-614.5. Uniform claims processing -- Electronic exchange of health**
1532 **information.**

1533 (1) Beginning July 1, 1993, all insurers offering health insurance shall use a uniform
1534 claim form and uniform billing and claim codes.

1535 (2) The uniform claim forms and billing codes shall be adopted and approved by the
1536 commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
1537 The commissioner shall consult with the director of the Division of Health Care Financing, the
1538 National Uniform Claim Form Task Force, and the National Uniform Billing Committee when
1539 adopting the uniform claims and billing codes.

1540 (3) (a) (i) Beginning July 1, 1995, all insurers shall offer compatible systems of
1541 electronic billing approved by the commissioner in accordance with Title 63G, Chapter 3, Utah
1542 Administrative Rulemaking Act.

1543 (ii) The systems approved by the commissioner may include monitoring and

*** PROTECTED ***

1544 disseminating information concerning eligibility and coverage of individuals.

1545 (iii) The commissioner shall coordinate the administrative rules adopted under the
1546 provisions of this section with the administrative rules adopted by the Department of Health for
1547 the implementation of the standards for the electronic exchange of clinical health information
1548 under Section 26-1-37. The department shall establish procedures for developing the rules
1549 adopted under this section, which ensure that the Department of Health is given the
1550 opportunity to comment on proposed rules.

1551 (b) The commissioner shall regulate any fees charged by insurers to the providers for:

1552 (i) uniform claim forms;

1553 (ii) electronic billing; or

1554 (iii) the electronic exchange of clinical health information permitted by Section 26-1-
1555 37.

1556 (4) Beginning July 1, 2009, the commissioner shall adopt administrative rules
1557 necessary to establish uniform electronic standards for the implementation of:

1558 (a) Section 31A-22-635, Uniform health insurance applications; and

1559 (b) the Internet portal created in Subsection 63M-1-2504(2), which shall:

1560 (i) organize and present available health insurance options for individuals and groups,
1561 including:

1562 (A) group plans;

1563 (B) individual plans; and

1564 (C) public programs;

1565 ~~(D) premium assistance through the Utah Premium Partnership program;~~

1566 (ii) create, display, and compare information required by Section 31A-22-613.5; and

1567 (iii) register the receipt and transmission of premium contributions from multiple

1568 sources for plans offered under Chapter 30, Part 2, Defined Contribution Arrangements.

1569 Section 5. Section **31A-22-618.5** is enacted to read:

1570 ~~31A-22-618.5. Health plan offerings. Delete this entire section or at a minimum~~

1571 see below changes.

1572 (1) The purpose of this section is to increase the range of health benefit plans available
1573 in the market.

1574 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
1575 Organizations and Limited Health Plans:

1576 (a) shall offer to potential purchasers ~~at least~~ one health benefit plan that is subject to
1577 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans
1578 ~~for every plan offered under this section~~; and
1579 (b) may if the provisions of Subsection (7) are met, offer to a potential purchaser a
1580 health benefit plan or limited health benefit plan that:
1581 (i) is not subject to one or more of the following:
1582 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
1583 (B) the limitation on point of service products in Subsections 31A-8-408(3) through
1584 (6);
1585 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
1586 Section 31A-8-101; or
1587 (D) unless required by federal law, mandated coverage required by the following
1588 sections and related administrative rules:
1589 (I) Section 31A-22-610.1 Adoption indemnity benefits;
1590 (II) Section 31A-22-623 Inborn metabolic errors;
1591 (III) Section 31A-22-624 Primary care physicians;
1592 (IV) Section 31A-22-626 Coverage of diabetes;
1593 (V) Section 31A-22-628 Standing referral to a specialist; or
1594 (VI) coverage mandates enacted by the state after January 1, 2009; and
1595 (ii) provides coverage for an emergency medical condition as required by Section 31A-
1596 22-627 as follows:
1597 (A) within the organization's service area, covered services shall include health care
1598 services from non-affiliated providers only when delay in receiving care from an affiliated
1599 provider could reasonably be expected to place the enrollee's health in serious jeopardy; and
1600 (B) outside the organization's service area, covered services shall include medically
1601 necessary health care services for the treatment of an emergency medical condition that are
1602 immediately required while the enrollee is outside the geographic limits of the organization's
1603 service area.
1604 (3) An insurer that offers a health benefit plan and is not subject to Chapter 8, Health
1605 Maintenance Organizations and Limited Health Plans:
1606 (a) shall offer to a potential purchaser ~~at least~~ one health benefit plan ~~for every health~~
1607 ~~benefit plan~~ that is subject to Sections 31A-22-617 and 31A-22-618; and
1608 (b) may, if the provisions of Subsection (7) are met, offer to potential purchasers a
1609 health benefit plan that:

1610 (i) is not subject to one or more of the following:
1611 (A) Subsection 31A-22-617(2);
1612 (B) Subsection 31A-22-617(7);
1613 (C) notwithstanding Subsection 31A-22-617(9), Section 31A-22-618; or
1614 (D) unless required by federal law, mandated coverage under the following:
1615 (I) Section 31A-22-610.1 Adoption indemnity benefits;
1616 (II) Section 31A-22-623 Inborn metabolic errors;
1617 (III) Section 31A-22-624 Primary care physicians;
1618 (IV) Section 31A-22-626 Coverage of diabetes;
1619 (V) Section 31A-22-628 Standing referral to a specialist; or
1620 (VI) coverage mandates enacted by the state after January 1, 2009; and
1621 (ii) (A) is subject to Section 31A-8-501; and
1622 (B) provides coverage of emergency care services as required by Section 31A-22-627
1623 by providing coverage in accordance with Subsection 31A-22-617(2).
1624 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
1625 Subsection (2)(b).
1626 (5) (a) Any difference in price between a health benefit plan offered under Subsection
1627 (2)(a) and one offered under Subsection (2)(b):
1628 (i) shall be based on actuarial differences in costs between the plans; and
1629 (ii) is subject to Subsection 31A-30-106(1)(f)(ii)(B).
1630 (b) Any difference in price between a health benefit plan offered under Subsections
1631 (3)(a) and (b):
1632 (i) shall be based on actuarial differences in costs between the plans; and
1633 (ii) is subject to Subsection 31A-30-106(1)(f)(ii)(B).
1634 (6) Nothing in this section limits the number of health benefit plans that an insurer may
1635 offer.
1636 (7) (a) An insurer may offer a health benefit plan that is free of state mandates, in
1637 accordance with this section, only if the mandate-free product is offered:
1638 (i) through the Internet portal created by Section 63M-1-2504; and
1639 (ii) through a defined contribution arrangement created by Chapter 30, Part 2, Defined
1640 Contribution Arrangements.
1641 (b) If an insurer meets the requirements of Subsection (7)(a), the insurer may also offer
1642 the mandate free product:
1643 (i) by a method other than the Internet portal; and

1644 (ii) in a defined benefit market.

1645 Section 6. Section **31A-22-633** is amended to read:

1646 **31A-22-633. Exemptions from standards.**

1647 [~~Notwithstanding the provisions of Title 31A, Insurance Code, any~~]

1648 (1) An accident and health insurer or health maintenance organization may offer a

1649 choice of coverage that is less or different than [is otherwise required by applicable state law

1650 if:] the Basic Health Care Plan or the Utah NetCare Basic Health Care Plan required by Section

1651 31A-22-613.5 if:

1652 [~~(+)~~] (a) the Department of Health offers a choice of coverage as part of a Medicaid

1653 waiver under Title 26, Chapter 18, Medical Assistance Act, which includes:

1654 [~~(+)~~] (i) less or different coverage than the basic coverage;

1655 [~~(+)~~] (ii) less or different coverage than is otherwise required in an insurance policy or

1656 health maintenance organization contract under applicable state law; or

1657 [~~(+)~~] (iii) less or different coverage than required by Subsection 31A-22-605(4)(b); and

1658 [~~(+)~~] (b) the choice of coverage offered by the carrier:

1659 [~~(+)~~] (i) is the same or similar coverage as the coverage offered by the Department of

1660 Health under Subsection (1);

1661 [~~(+)~~] (ii) is offered to the same or similar population as the coverage offered by the

1662 Department of Health under Subsection (1); and

1663 [~~(+)~~] (iii) contains an explanation for each insured of coverage exclusions and

1664 limitations[?].

1665 (2) Notwithstanding Section 31A-22-613.5, and subject to Subsection (3), an insurer

1666 may offer to potential purchasers a health benefit plan that:

1667 (a) is not subject to state mandates as provided in Section 31A-22-618.5;

1668 (b) includes coverage that applies against a plan year deductible and out-of-pocket

1669 maximum for:

1670 (i) in-patient hospital and emergency care;

1671 (ii) out-patient hospital services;

1672 (iii) physician office visits;

1673 (iv) diagnostic services, x-rays and laboratory services; and

1674 (v) prescription drugs;

1675 (c) has an annual lifetime maximum not lower than the annual lifetime maximums

1676 established for the basic health care plan or Utah NetCare Basic Health Care Plan offered

1677 under Section 31A-22-613.5;

1678 (d) (i) in accordance with Subsection (2)(d)(ii), covers generally accepted preventive
1679 care services allowed by federal law, including:
1680 (A) immunizations;
1681 (B) age appropriate cancer screenings as determined by the American Medical
1682 Association.” (or ask UMA what the best standard is):
1683 (C) well-child exams; and
1684 (D) preventive care prescription medications, including generics medications for:
1685 (I) diabetes control;
1686 (II) asthma control; and
1687 (III) blood pressure control; and
1688 (ii) covers the preventive care required by Subsection (2)(d)(i):
1689 (A) without applying a deductible; and
1690 (B) with a co-payment:
1691 (I) that does not exceed \$15 per visit, service, or generic prescription; and
1692 (II) that may exceed \$15 per prescription for non-generic drugs;
1693 (e) entitles enrollees to the same discounted price for covered benefits and covered
1694 services without regard to whether:
1695 (i) the patient or insurer is responsible for payment for the service or benefit; or
1696 (ii) the patient has exhausted the maximum benefit for the covered service under the
1697 plan;
1698 (f) has annual deductible of not more than:
1699 (i) \$5,800 fo an individual; and
1700 (ii) \$7,500 for a family;
1701 (g) has an annual out of pocket maximum cost that:
1702 (i) includes in-network deductibles, co-payments and co-insurance; and
1703 (ii) is no higher that the highest out-of-pocket amount allowed in a federally qualifies
1704 high deductible health plan; and
1705 (h) has an actuarial equivalent of not more than 100% of the Utah NetCare Basic
1706 Health Care Plan high deductible option.
1707 (3) An insurer who offers a health benefit plan under Subsection (2), shall:
1708 (a) if the insurer offers any small employer health benefit plans subject to Chapter 30,
1709 Individual, Small employer, and Group Health Insurance Act, offer at least one product in a
1710 defined contribution arrangement through the Internet portal in accordance with Chapter 30,
1711 Part 2, Defined Contribution Arrangements;

1712 (b) offer the health benefit plan through the Internet portal created under Section 63M-
1713 1-2504; and

1714 (c) offer to a potential purchaser of a health benefit plan under Subsection (2), an
1715 optional stand-alone policy or rider for basic preventive dental services.

1716 (4) This section does not limit the number of health benefit plans an insurer may offer
1717 in the state.

1718 ~~[(3) the]~~ (5) The commissioner and the executive director of the Department of Health
1719 shall report to the Health and Human Services Interim Committee prior to November 15 of
1720 each year concerning:

1721 (a) the number of lives covered under any policy offered under the provisions of this
1722 section or under the Medicaid waiver described in ~~[Subsection (1)]~~ Subsections (1) and (2);

1723 (b) the claims experienced under the policies or Medicaid programs described in
1724 ~~[Subsection (3)(a)]~~ Subsections (1) and (2);

1725 (c) any cost shifting to the private sector for care not covered under the programs or
1726 policies described in ~~[Subsection (3)(a)]~~ Subsections (1) and (2); and

1727 (d) efforts or agreements between the Department of Health, the commissioner,
1728 insurers regulated under this chapter, and health care providers regarding combining publicly
1729 funded coverage with private, employer-based coverage to increase benefits and health care
1730 coverage.

1731 Section 7. Section **31A-22-722** is amended to read:

1732 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

1733 (1) An insured has the right to extend the employee's coverage under the current
1734 employer's group policy for a period of ~~six~~ 12 months, except as provided in Subsection (2).

1735 The right to extend coverage includes:

1736 (a) voluntary termination;

1737 (b) involuntary termination;

1738 (c) retirement;

1739 (d) death;

1740 (e) divorce or legal separation;

1741 (f) loss of dependent status;

1742 (g) sabbatical;

1743 (h) any disability;

1744 (i) leave of absence; or

1745 (j) reduction of hours.

1746 (2) (a) Notwithstanding the provisions of Subsection (1), an employee does not have
1747 the right to extend coverage under the current employer's group policy if the employee:
1748 (i) failed to pay any required individual contribution;
1749 (ii) acquires other group coverage covering all preexisting conditions including
1750 maternity, if the coverage exists;
1751 (iii) performed an act or practice that constitutes fraud in connection with the coverage;
1752 (iv) made an intentional misrepresentation of material fact under the terms of the
1753 coverage;
1754 (v) was terminated for gross misconduct;
1755 (vi) has not been continuously covered under the current employer's group policy for a
1756 period of ~~six~~ three months immediately prior to the termination of the policy due to the
1757 events set forth in Subsection (1); ~~or~~
1758 (vii) is eligible for any extension of coverage required by federal law~~[-];~~ or
1759 (viii) elected alternative coverage under Section 31A-22-724.
1760 (b) The right to extend coverage under Subsection (1) applies to any spouse or
1761 dependent coverages, including a surviving spouse or dependents whose coverage under the
1762 policy terminates by reason of the death of the employee or member.
1763 (3) (a) The employer shall provide written notification of the right to extend group
1764 coverage and the payment amounts required for extension of coverage, including the manner,
1765 place, and time in which the payments shall be made to:
1766 (i) the terminated insured;
1767 (ii) if Section 31A-22-612 applies, the ex-spouse; or
1768 (iii) if Subsection (2)(b) applies:
1769 (A) to a surviving spouse; and
1770 (B) the guardian of surviving dependents, if different from a surviving spouse.
1771 (b) The notification shall be sent first class mail within 30 days after the termination
1772 date of the group coverage to:
1773 (i) the terminated insured's home address as shown on the records of the employer;
1774 (ii) the address of the surviving spouse, if different from the insured's address and if
1775 shown on the records of the employer;
1776 (iii) the guardian of any dependents address, if different from the insured's address, and
1777 if shown on the records of the employer; and
1778 (iv) the address of the ex-spouse, if shown on the records of the employer.
1779 (4) The insurer shall provide the employee, spouse, or any eligible dependent the

*** PROTECTED ***

1780 opportunity to extend the group coverage at the payment amount stated in this Subsection (3)
1781 if:

1782 (a) the employer policyholder does not provide the terminated insured the written
1783 notification required by Subsection (3)(a); and

1784 (b) the employee or other individual eligible for extension contacts the insurer within
1785 60 days of coverage termination.

1786 (5) The premium amount for extended group coverage may not exceed 102% of the
1787 group rate in effect for a group member, including an employer's contribution, if any, for a
1788 group insurance policy.

1789 (6) Except as provided in this Subsection (6), the coverage extends without
1790 interruption for ~~six~~ 12 months and may not terminate if the terminated insured or, with
1791 respect to a minor, the parent or guardian of the terminated insured:

1792 (a) elects to extend group coverage within 60 days of losing group coverage; and

1793 (b) tenders the amount required to the employer or insurer.

1794 (7) The insured's coverage may be terminated prior to ~~six~~ 12 months if the terminated
1795 insured:

1796 (a) establishes residence outside of this state;

1797 (b) moves out of the insurer's service area;

1798 (c) fails to pay premiums or contributions in accordance with the terms of the policy,
1799 including any timeliness requirements;

1800 (d) performs an act or practice that constitutes fraud in connection with the coverage;

1801 (e) makes an intentional misrepresentation of material fact under the terms of the
1802 coverage;

1803 (f) becomes eligible for similar coverage under another group policy; or

1804 (g) employer's coverage is terminated, except as provided in Subsection (8).

1805 (8) If the current employer coverage is terminated and the employer replaces coverage
1806 with similar coverage under another group policy, without interruption, the terminated insured,
1807 spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have
1808 the right to obtain extension of coverage under the replacement group policy:

1809 (a) for the balance of the period the terminated insured would have extended coverage
1810 under the replaced group policy; and

1811 (b) if the terminated insured is otherwise eligible for extension of coverage.

1812 (9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the
1813 employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of
1814 the insured, the surviving spouse, or guardian of any dependents, written notification of the
1815 right to an individual conversion policy under Section 31A-22-723.

1816 (b) The notification required by Subsection (9)(a):

1817 (i) shall be sent first class mail to:

1818 (A) the insured's last-known address as shown on the records of the employer;

1819 (B) the address of the surviving spouse, if different from the insured's address, and if
1820 shown on the records of the employer;

1821 (C) the guardian of any dependents last known address as shown on the records of the
1822 employer, if different from the address of the surviving spouse; and

1823 (D) the address of the ex-spouse as shown on the records of the employer, if
1824 applicable; and

1825 (ii) shall contain the name, address, and telephone number of the insurer that will
1826 provide the conversion coverage.

1827 Section 8. Section **31A-22-723** is amended to read:

1828 **31A-22-723. Group and blanket conversion coverage.**

1829 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection
1830 (3), all policies of accident and health insurance offered on a group basis under this title, or
1831 Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that
1832 a person whose insurance under the group policy has been terminated is entitled to choose a
1833 converted individual policy of similar accident and health insurance.

1834 (2) A person who has lost group coverage may elect conversion coverage with the
1835 insurer that provided prior group coverage if the person:

1836 [~~(a) has been continuously covered for a period of six months by the group policy or~~
1837 ~~the group's preceding policies immediately prior to termination;~~]

1838 [~~(b)~~] (a) has exhausted either:

1839 (i) Utah mini-COBRA coverage as required in Section 31A-22-722 [~~or~~];

1840 (ii) alternative COBRA coverage under Section 31A-22-724; or

1841 (iii) federal COBRA coverage;

1842 [~~(b)~~] (b) has not acquired or is not covered under any other group coverage that covers

*** PROTECTED ***

1843 all preexisting conditions, including maternity, if the coverage exists; and
1844 [~~(d)~~] (c) resides in the insurer's service area.

1845 (3) This section does not apply if the person's prior group coverage:
1846 (a) is a stand alone policy that only provides one of the following:
1847 (i) catastrophic benefits;
1848 (ii) aggregate stop loss benefits;
1849 (iii) specific stop loss benefits;
1850 (iv) benefits for specific diseases;
1851 (v) accidental injuries only;
1852 (vi) dental; or
1853 (vii) vision;
1854 (b) is an income replacement policy;
1855 (c) was terminated because the insured:
1856 (i) failed to pay any required individual contribution;
1857 (ii) performed an act or practice that constitutes fraud in connection with the coverage;
1858 or
1859 (iii) made intentional misrepresentation of material fact under the terms of coverage; or
1860 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or
1861 31A-30-107(2)(a).

1862 (4) (a) The employer shall provide written notification of the right to an individual
1863 conversion policy within 30 days of the insured's termination of coverage to:
1864 (i) the terminated insured;
1865 (ii) the ex-spouse; or
1866 (iii) in the case of the death of the insured:
1867 (A) the surviving spouse; and
1868 (B) the guardian of any dependents, if different from a surviving spouse.
1869 (b) The notification required by Subsection (4)(a) shall:
1870 (i) be sent by first class mail;
1871 (ii) contain the name, address, and telephone number of the insurer that will provide

*** PROTECTED ***

1872 the conversion coverage; and

1873 (iii) be sent to the insured's last-known address as shown on the records of the
1874 employer of:

1875 (A) the insured;

1876 (B) the ex-spouse; and

1877 (C) if the policy terminates by reason of the death of the insured to:

1878 (I) the surviving spouse; and

1879 (II) the guardian of any dependents, if different from a surviving spouse.

1880 (5) (a) An insurer is not required to issue a converted policy which provides benefits in
1881 excess of those provided under the group policy from which conversion is made.

1882 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health
1883 benefit plan, the employee or member must be offered:

1884 (i) at least the basic benefit plan ~~through December 31, 2009; and~~

1885 ~~(ii) beginning January 1, 2010, at least the Utah NetCare Basic Health Care plan,~~ as

1886 provided in Section 31A-22-613.5.

1887 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels
1888 provided under the group policy, the conversion policy may offer benefits which are
1889 substantially similar to those provided under the group policy.

1890 (6) Written application for the converted policy shall be made and the first premium
1891 paid to the insurer no later than 60 days after termination of the group accident and health
1892 insurance.

1893 (7) The converted policy shall be issued without evidence of insurability.

1894 (8) (a) The initial premium for the converted policy for the first 12 months and
1895 subsequent renewal premiums shall be determined in accordance with premium rates
1896 applicable to age, class of risk of the person, and the type and amount of insurance provided.

1897 (b) The initial premium for the first 12 months may not be raised based on pregnancy
1898 of a covered insured.

1899 (c) The premium for converted policies shall be payable monthly or quarterly as
1900 required by the insurer for the policy form and plan selected, unless another mode or premium
1901 payment is mutually agreed upon.

1902 (9) The converted policy becomes effective at the time the insurance under the group
1903 policy terminates.

1904 (10) (a) A newly issued converted policy covers the employee or the member and must
1905 also cover all dependents covered by the group policy at the date of termination of the group
1906 coverage.

1907 (b) The only dependents that may be added after the policy has been issued are
1908 children and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6)
1909 and (7).

1910 (c) At the option of the insurer, a separate converted policy may be issued to cover any
1911 dependent.

1912 (11) (a) To the extent the group policy provided maternity benefits, the conversion
1913 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group
1914 policy or the conversion policy until termination of a pregnancy that exists on the date of
1915 conversion if one of the following is pregnant on the date of the conversion:

1916 (i) the insured;

1917 (ii) a spouse of the insured; or

1918 (iii) a dependent of the insured.

1919 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs
1920 after the date of conversion.

1921 (12) Except as provided in this Subsection (12), a converted policy is renewable with
1922 respect to all individuals or dependents at the option of the insured. An insured may be
1923 terminated from a converted policy for the following reasons:

1924 (a) a dependent is no longer eligible under the policy;

1925 (b) for a network plan, if the individual no longer lives, resides, or works in:

1926 (i) the insured's service area; or

1927 (ii) the area for which the covered carrier is authorized to do business;

1928 (c) the individual fails to pay premiums or contributions in accordance with the terms
1929 of the converted policy, including any timeliness requirements;

1930 (d) the individual performs an act or practice that constitutes fraud in connection with
1931 the coverage;

1932 (e) the individual makes an intentional misrepresentation of material fact under the
1933 terms of the coverage; or

1934 (f) coverage is terminated uniformly without regard to any health status-related factor
1935 relating to any covered individual.

1936 (13) Conditions pertaining to health may not be used as a basis for classification under
1937 this section.

1938 Section 9. Section **31A-22-724** is enacted to read:
1939 **31A-22-724. Offer of alternative coverage -- Utah NetCare Basic Health Care**
1940 **Plan.**
1941 (1) For purposes of this section, "alternative coverage" means a high deductible and
1942 low deductible Utah Netcare Basic Health Care Plan adopted in accordance with Section 31A-
1943 22-613.5.
1944 (2) (a) Beginning January 1, 2010, and except as provided in Subsection (3), a person
1945 may elect alternative coverage under this section if the person:
1946 (i) is eligible for continuation of employer group coverage under federal COBRA laws;
1947 (ii) is eligible for continuation of employer group coverage under state mini-COBRA
1948 under Section 31A-22-722; or
1949 (iii) is eligible for a conversion to an individual plan from:
1950 (A) an employer's group coverage under Section 31A-22-723; or
1951 (B) the exhaustion of benefits under:
1952 (I) alternative coverage elected in place of federal COBRA; or
1953 (II) state mini-COBRA under Section 31A-22-722.
1954 (b) The right to extend coverage under Subsection (2)(a) applies to any spouse or
1955 dependent coverages, including a surviving spouse or dependents whose coverage under the
1956 policy terminates by reason of the death of the employee or member.
1957 (3) If a person elects federal COBRA coverage, or state mini-COBRA coverage under
1958 Section 31A-22-722, the person is not eligible to elect alternative coverage under this section
1959 until the person is eligible to convert coverage to an individual policy under the provisions of
1960 Section 31A-22-723.
1961 (4) (a) Within 30 days of the termination of the health benefit plan of an employer's
1962 employee, the employer shall provide written notification of the right to elect alternative
1963 coverage to:
1964 (i) the terminated insured;
1965 (ii) if Section 31A-22-612 applies, the ex-spouse; or
1966 (iii) if Subsection (2)(b) applies:
1967 (A) the surviving spouse; and
1968 (B) the guardian of any dependents, if different from a surviving spouse.
1969 (b) The notification required by Subsection (4)(a) shall:
1970 (i) be sent by first class mail;
1971 (ii) contain the name, address, and telephone number of the insurer that will provide

*** PROTECTED ***

1972 the alternative coverage; and

1973 (iii) be sent to the last-known address as shown on the records of the employer of:

1974 (A) the insured;

1975 (B) if Subsection 31A-22-612 applies, the ex-spouse; and

1976 (C) if Subsection (2)(b) applies to:

1977 (I) the surviving spouse; and

1978 (II) the address of the guardian of any dependents, if different from a surviving spouse,

1979 if shown on the records of the employer.

1980 (5) Written application for the alternative coverage shall be made and the first

1981 premium paid to the insurer no later than 60 days after:

1982 (a) termination of the employee's health benefit plan if the election of alternative

1983 coverage is made in place of federal COBRA coverage or state mini-COBRA coverage; or

1984 (b) exhaustion of federal COBRA coverage or state mini-COBRA coverage if

1985 alternative coverage is elected in accordance with Subsection (3).

1986 (6) The alternative coverage shall be issued without evidence of insurability.

1987 (7) If an individual elects alternative coverage in place of federal COBRA coverage or

1988 state mini-COBRA coverage under Section 31A-22-722, the following applies to the

1989 alternative coverage:

1990 (a) Subsection 31A-22-722(4), except that the premium amount is established under

1991 Section 31A-22-613.5; and

1992 (b) Subsections 31A-22-722(5), (6), (7) and (9).

1993 (8) If an individual elects alternative coverage as a conversion policy, the provisions of

1994 Subsections 31A-22-723(8) through (13) apply to the alternative coverage.

1995 (9) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall prior to

1996 September 1, 2009, file an alternative coverage policy with the department that complies with

1997 this Section and Section 31A-22-613.5.

1998 (b) The department shall:

1999 (i) approve the plans that comply with this section and Section 31A-22-613.5; and

2000 (ii) by October 1, 2009, develop a model letter for employers to use to notify an

*** PROTECTED ***

2001 employee of the employee's options for alternative coverage.

2002 Section 10. Section **31A-23a-401** is amended to read:

2003 **31A-23a-401. Disclosure of conflicting interests.**

2004 (1) (a) Except as provided under Subsection (1)(b):

2005 (i) a licensee under this chapter may not act in the same or any directly related

2006 transaction as:

2007 (A) a producer for the insured or consultant; and

2008 (B) producer for the insurer; and

2009 (ii) a producer for the insured or consultant may not recommend or encourage the

2010 purchase of insurance from or through an insurer or other producer:

2011 (A) of which the producer for the insured or consultant or producer for the insured's or

2012 consultant's spouse is an owner, executive, or employee; or

2013 (B) to which the producer for the insured or consultant has the type of relation that a

2014 material benefit would accrue to the producer for the insured or consultant or spouse as a result

2015 of the purchase.

2016 (b) Subsection (1)(a) does not apply if the following three conditions are met:

2017 (i) Prior to performing the consulting services, the producer for the insured or

2018 consultant shall disclose to the client, prominently, in writing:

2019 (A) the producer for the insured's or consultant's interest as a producer for the insurer,

2020 or the relationship to an insurer or other producer; and

2021 (B) that as a result of those interests, the producer for the insured's or the consultant's

2022 recommendations should be given appropriate scrutiny.

2023 (ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing,

2024 after the disclosure required under Subsection (1)(b)(i), but before performing the requested

2025 services.

2026 (iii) Any report resulting from requested services shall contain a copy of the disclosure

2027 made under Subsection (1)(b)(i).

2028 (2) A licensee under this chapter may not act as to the same client as both a producer

2029 for the insurer and a producer for the insured without the client's prior written consent based on

2030 full disclosure.

2031 (3) Whenever a person applies for insurance coverage through a producer for the

2032 insured, the producer for the insured shall disclose to the applicant, in writing, that the

*** PROTECTED ***

2033 producer for the insured is not the producer for the insurer or the potential insurer. This
2034 disclosure shall also inform the applicant that the applicant likely does not have the benefit of
2035 an insurer being financially responsible for the conduct of the producer for the insured.

2036 (4) If a licensee is subject to both this section and Subsection 31A-23a-501(4), the
2037 licensee shall provide the disclosures required under each statute.

2038 Section 11. Section **31A-23a-501** is amended to read:

2039 **31A-23a-501. Licensee compensation.**

2040 (1) As used in this section:

2041 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
2042 licensee from:

2043 (i) commission amounts deducted from insurance premiums on insurance sold by or
2044 placed through the licensee; or

2045 (ii) commission amounts received from an insurer or another licensee as a result of the
2046 sale or placement of insurance.

2047 (b) (i) "Compensation from an insurer or third party" means fees, awards, overrides,
2048 bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of
2049 valuable consideration:

2050 (A) whether or not payable pursuant to a written agreement; and

2051 (B) received from:

2052 (I) an insurer; or

2053 (II) a third party to the transaction for the sale or placement of insurance.

2054 (ii) "Compensation from an insurer or third party administrator" does not mean
2055 compensation from a customer that is:

2056 (A) a fee or pass-through costs as provided in Subsection (1)(e); or

2057 (B) a fee or amount collected by or paid to the producer that does not exceed an
2058 amount established by the commissioner.

2059 (c) (i) "Customer" means:

2060 (A) the person signing the application or submission for insurance; or

2061 (B) the authorized representative of the insured actually negotiating the placement of

*** PROTECTED ***

2062 insurance with the producer.

2063 (ii) "Customer" does not mean a person who is:

2064 (A) a participant or beneficiary of an employee benefit plan; or

2065 (B) covered by a group or blanket insurance policy or group annuity contract sold,

2066 solicited, or negotiated by the producer or affiliate.

2067 ~~(b)~~ (d) (i) "Noncommission compensation" includes all funds paid to or credited for
2068 the benefit of a licensee other than commission compensation.

2069 (ii) "Noncommission compensation" does not include charges for pass-through costs
2070 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

2071 ~~(e)~~ (e) "Pass-through costs" include:

2072 (i) costs for copying documents to be submitted to the insurer; and

2073 (ii) bank costs for processing cash or credit card payments.

2074 (iii) all commission payments are required to be publicly disclosed on the portal.

2075 (2) A licensee may receive from an insured or from a person purchasing an insurance
2076 policy, noncommission compensation if the noncommission compensation is stated on a
2077 separate, written disclosure.

2078 (a) The disclosure required by this Subsection (2) shall:

2079 (i) include the signature of the insured or prospective insured acknowledging the
2080 noncommission compensation;

2081 (ii) clearly specify the amount or extent of the noncommission compensation; and

2082 (iii) be provided to the insured or prospective insured before the performance of the
2083 service.

2084 (b) Noncommission compensation shall be:

2085 (i) limited to actual or reasonable expenses incurred for services; and

2086 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
2087 business or for a specific service or services.

2088 (c) A copy of the signed disclosure required by this Subsection (2) must be maintained
2089 by any licensee who collects or receives the noncommission compensation or any portion
2090 ~~thereof~~ of the noncommission compensation.

2091 (d) All accounting records relating to noncommission compensation shall be
2092 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

2093 (3) (a) A licensee may receive noncommission compensation when acting as a

*** PROTECTED ***

2094 producer for the insured in connection with the actual sale or placement of insurance if:

2095 (i) the producer and the insured have agreed on the producer's noncommission
2096 compensation; and

2097 (ii) the producer has disclosed to the insured the existence and source of any other
2098 compensation that accrues to the producer as a result of the transaction.

2099 (b) The disclosure required by this Subsection (3) shall:

2100 (i) include the signature of the insured or prospective insured acknowledging the
2101 noncommission compensation;

2102 (ii) clearly specify the amount or extent of the noncommission compensation and the
2103 existence and source of any other compensation; and

2104 (iii) be provided to the insured or prospective insured before the performance of the
2105 service.

2106 (c) The following additional noncommission compensation is authorized:

2107 (i) compensation received by a producer of a compensated corporate surety who under
2108 procedures approved by a rule or order of the commissioner is paid by surety bond principal
2109 debtors for extra services;

2110 (ii) compensation received by an insurance producer who is also licensed as a public
2111 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
2112 claim adjustment, so long as the producer does not receive or is not promised compensation for
2113 aiding in the claim adjustment prior to the occurrence of the claim;

2114 (iii) compensation received by a consultant as a consulting fee, provided the consultant
2115 complies with the requirements of Section 31A-23a-401; or

2116 (iv) other compensation arrangements approved by the commissioner after a finding
2117 that they do not violate Section 31A-23a-401 and are not harmful to the public.

2118 (4) (a) For purposes of this Subsection (4), "producer" includes:

2119 (i) a producer;

2120 (ii) an affiliate of a producer; or

2121 (iii) a consultant.

2122 (b) Beginning January 1, 2010, in addition to any other disclosures required by this

*** PROTECTED ***

2123 section, a producer may not accept or receive any compensation from an insurer or third party
2124 administrator for that placement of health care insurance unless prior to the customer's
2125 purchase or renewal of health care insurance the producer:

2126 (i) obtains the customer's signed acknowledgment that the compensation from an
2127 insurer or third party administrator may be received by the producer; and

2128 (ii) provides a description of the possible type and amount of compensation from an
2129 insurer or third party administrator for that placement.

2130 (c) A copy of the signed acknowledgment required by Subsection (4)(b)(i) must be
2131 maintained by the licensee who collects or receives any part of the compensation from an
2132 insurer or third party administrator in a manner that facilitates an audit.

2133 (d) This Subsection (4) does not apply to:

2134 (i) a person licensed as a producer who acts only as an intermediary between an insurer
2135 and the customer's producer, including a managing general agent; or

2136 (ii) the placement of insurance in a secondary or residual market.

2137 ~~[(4)]~~ (5) This section does not alter the right of any licensee to recover from an insured
2138 the amount of any premium due for insurance effected by or through that licensee or to charge
2139 a reasonable rate of interest upon past-due accounts.

2140 ~~[(5)]~~ (6) This section does not apply to bail bond producers or bail enforcement agents
2141 as defined in Section 31A-35-102.

2142 Section 12. Section **31A-30-102** is amended to read:

2143 **31A-30-102. Purpose statement.**

2144 The purpose of this chapter is to:

2145 (1) prevent abusive rating practices;

2146 (2) require disclosure of rating practices to purchasers;

2147 (3) establish rules regarding:

2148 (a) a universal individual and small group application; and

2149 (b) renewability of coverage;

2150 (4) improve the overall fairness and efficiency of the individual and small group
2151 insurance market; ~~and~~

2152 (5) provide increased access for individuals and small employers to health insurance~~[-];~~
2153 and

2154 (6) provide small employers and individuals the opportunity to establish a defined

*** PROTECTED ***

2155 contribution arrangement to purchase a health benefit plan.

2156 Section 13. Section **31A-30-103** is amended to read:

2157 **31A-30-103. Definitions.**

2158 As used in this chapter:

2159 (1) "Actuarial certification" means a written statement by a member of the American
2160 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
2161 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,
2162 including review of the appropriate records and of the actuarial assumptions and methods used
2163 by the covered carrier in establishing premium rates for applicable health benefit plans.

2164 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
2165 through one or more intermediaries, controls or is controlled by, or is under common control
2166 with, a specified entity or person.

2167 (3) "Base premium rate" means, for each class of business as to a rating period, the
2168 lowest premium rate charged or that could have been charged under a rating system for that
2169 class of business by the covered carrier to covered insureds with similar case characteristics for
2170 health benefit plans with the same or similar coverage.

2171 (4) "Basic coverage" means the coverage provided in:

2172 (a) the Basic Health Care Plan under Subsection 31A-22-613.5(2)[;] ~~until December~~
2173 ~~31, 2009; and~~

2174 ~~(b) the Utah NetCare Basic Health Plan under Subsection 31A-22-613.5(2) beginning~~
2175 ~~January 1, 2010.~~

2176 (5) "Carrier" means any person or entity that provides health insurance in this state
2177 including:

- 2178 (a) an insurance company;
 - 2179 (b) a prepaid hospital or medical care plan;
 - 2180 (c) a health maintenance organization;
 - 2181 (d) a multiple employer welfare arrangement; and
 - 2182 (e) any other person or entity providing a health insurance plan under this title.
- 2183 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means

*** PROTECTED ***

2184 demographic or other objective characteristics of a covered insured that are considered by the
2185 carrier in determining premium rates for the covered insured.

2186 (b) "Case characteristics" do not include:

2187 (i) duration of coverage since the policy was issued;

2188 (ii) claim experience; and

2189 (iii) health status.

2190 (7) "Class of business" means all or a separate grouping of covered insureds

2191 established under Section 31A-30-105.

2192 (8) "Conversion policy" means a policy providing coverage under the conversion

2193 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

2194 (9) "Covered carrier" means any individual carrier or small employer carrier subject to

2195 this chapter.

2196 (10) "Covered individual" means any individual who is covered under a health benefit

2197 plan subject to this chapter.

2198 (11) "Covered insureds" means small employers and individuals who are issued a

2199 health benefit plan that is subject to this chapter.

2200 (12) "Dependent" means an individual to the extent that the individual is defined to be

2201 a dependent by:

2202 (a) the health benefit plan covering the covered individual; and

2203 (b) Chapter 22, Part 6, Accident and Health Insurance.

2204 (13) "Established geographic service area" means a geographical area approved by the

2205 commissioner within which the carrier is authorized to provide coverage.

2206 (14) "Index rate" means, for each class of business as to a rating period for covered

2207 insureds with similar case characteristics, the arithmetic average of the applicable base

2208 premium rate and the corresponding highest premium rate.

2209 (15) "Individual carrier" means a carrier that provides coverage on an individual basis

2210 through a health benefit plan regardless of whether:

2211 (a) coverage is offered through:

2212 (i) an association;

2213 (ii) a trust;

2214 (iii) a discretionary group; or

2215 (iv) other similar groups; or

2216 (b) the policy or contract is situated out-of-state.

2217 (16) "Individual conversion policy" means a conversion policy issued to:

2218 (a) an individual; or

2219 (b) an individual with a family.

2220 (17) "Individual coverage count" means the number of natural persons covered under a

2221 carrier's health benefit products that are individual policies.

2222 (18) "Individual enrollment cap" means the percentage set by the commissioner in

2223 accordance with Section 31A-30-110.

2224 (19) "New business premium rate" means, for each class of business as to a rating

2225 period, the lowest premium rate charged or offered, or that could have been charged or offered,

2226 by the carrier to covered insureds with similar case characteristics for newly issued health

2227 benefit plans with the same or similar coverage.

2228 (20) "Plan year" means the year that is designated as the plan year in the plan

2229 document of a group health plan, except that if the plan document does not designate a plan

2230 year or if there is not a plan document, the plan year is:

2231 (a) the deductible or limit year used under the plan;

2232 (b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

2233 (c) if the plan does not impose a deductible or limit on a yearly basis and either the

2234 plan is not insured or the insurance policy is not renewed on an annual basis, the employer's

2235 taxable year; or

2236 (d) in any case not described in Subsections (20)(a) through (c), the calendar year.

2237 (21) "Preexisting condition" is as defined in Section 31A-1-301.

2238 (22) "Premium" means all monies paid by covered insureds and covered individuals as

2239 a condition of receiving coverage from a covered carrier, including any fees or other

2240 contributions associated with the health benefit plan.

2241 (23) (a) "Rating period" means the calendar period for which premium rates

2242 established by a covered carrier are assumed to be in effect, as determined by the carrier.

2243 (b) A covered carrier may not have:

2244 (i) more than one rating period in any calendar month; and

2245 (ii) no more than 12 rating periods in any calendar year.

2246 (24) "Resident" means an individual who has resided in this state for at least 12

2247 consecutive months immediately preceding the date of application.

2248 (25) "Short-term limited duration insurance" means a health benefit product that:

2249 (a) is not renewable; and

2250 (b) has an expiration date specified in the contract that is less than 364 days after the
2251 date the plan became effective.

2252 (26) "Small employer carrier" means a carrier that provides health benefit plans
2253 covering eligible employees of one or more small employers in this state, regardless of
2254 whether:

2255 (a) coverage is offered through:

2256 (i) an association;

2257 (ii) a trust;

2258 (iii) a discretionary group; or

2259 (iv) other similar grouping; or

2260 (b) the policy or contract is situated out-of-state.

2261 (27) "Uninsurable" means an individual who:

2262 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
2263 underwriting criteria established in Subsection 31A-29-111(5); or

2264 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

2265 (ii) has a condition of health that does not meet consistently applied underwriting
2266 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)
2267 and (j) for which coverage the applicant is applying.

2268 (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
2269 purposes of this formula:

2270 (a) "CI" means the carrier's individual coverage count as of December 31 of the
2271 preceding year; and

2272 (b) "UC" means the number of uninsurable individuals who were issued an individual
2273 policy on or after July 1, 1997.

2274 Section 14. Section **31A-30-107** is amended to read:

2275 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
2276 **nonrenewal.**

2277 (1) Except as otherwise provided in this section, a small employer health benefit plan
2278 is renewable and continues in force:

2279 (a) with respect to all eligible employees and dependents; and

2280 (b) at the option of the plan sponsor.

2281 (2) A small employer health benefit plan may be discontinued or nonrenewed:

2282 (a) for a network plan, if:

2283 (i) there is no longer any enrollee under the group health plan who lives, resides, or

*** PROTECTED ***

2284 works in:

2285 (A) the service area of the covered carrier; or

2286 (B) the area for which the covered carrier is authorized to do business; and

2287 (ii) in the case of the small employer market, the small employer carrier applies the

2288 same criteria the small employer carrier would apply in denying enrollment in the plan under

2289 Subsection 31A-30-108(7); or

2290 (b) for coverage made available in the small or large employer market only through an

2291 association, if:

2292 (i) the employer's membership in the association ceases; and

2293 (ii) the coverage is terminated uniformly without regard to any health status-related

2294 factor relating to any covered individual.

2295 (3) A small employer health benefit plan may be discontinued if:

2296 (a) a condition described in Subsection (2) exists;

2297 (b) except as prohibited by Subsection 31A-30-202(3), the plan sponsor fails to pay

2298 premiums or contributions in accordance with the terms of the contract;

2299 (c) the plan sponsor:

2300 (i) performs an act or practice that constitutes fraud; or

2301 (ii) makes an intentional misrepresentation of material fact under the terms of the

2302 coverage;

2303 (d) the covered carrier:

2304 (i) elects to discontinue offering a particular small employer health benefit product

2305 delivered or issued for delivery in this state; and

2306 (ii) (A) provides notice of the discontinuation in writing:

2307 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee;

2308 and

2309 (II) at least 90 days before the date the coverage will be discontinued;

2310 (B) provides notice of the discontinuation in writing:

2311 (I) to the commissioner; and

2312 (II) at least three working days prior to the date the notice is sent to the affected plan

*** PROTECTED ***

2313 sponsors, employees, and dependents of the plan sponsors or employees;

2314 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all

2315 other small employer health benefit products currently being offered by the small employer

2316 carrier in the market; and

2317 (D) in exercising the option to discontinue that product and in offering the option of

2318 coverage in this section, acts uniformly without regard to:

2319 (I) the claims experience of a plan sponsor;

2320 (II) any health status-related factor relating to any covered participant or beneficiary;

2321 or

2322 (III) any health status-related factor relating to any new participant or beneficiary who

2323 may become eligible for the coverage; or

2324 (e) the covered carrier:

2325 (i) elects to discontinue all of the covered carrier's small employer health benefit plans

2326 in:

2327 (A) the small employer market;

2328 (B) the large employer market; or

2329 (C) both the small employer and large employer markets; and

2330 (ii) (A) provides notice of the discontinuation in writing:

2331 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee;

2332 and

2333 (II) at least 180 days before the date the coverage will be discontinued;

2334 (B) provides notice of the discontinuation in writing:

2335 (I) to the commissioner in each state in which an affected insured individual is known

2336 to reside; and

2337 (II) at least 30 working days prior to the date the notice is sent to the affected plan

2338 sponsors, employees, and the dependents of the plan sponsors or employees;

2339 (C) discontinues and nonrenews all plans issued or delivered for issuance in the

2340 market; and

2341 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

2342 (4) A small employer health benefit plan may be discontinued or nonrenewed:

2343 (a) if a condition described in Subsection (2) exists; or

2344 (b) for noncompliance with the insurer's employer contribution requirements.

2345 (5) A small employer health benefit plan may be nonrenewed:
2346 (a) if a condition described in Subsection (2) exists; or
2347 (b) for noncompliance with the insurer's minimum participation requirements.
2348 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
2349 discontinued if after issuance of coverage the eligible employee:
2350 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
2351 or
2352 (ii) makes an intentional misrepresentation of material fact in connection with the
2353 coverage.
2354 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
2355 (i) 12 months after the date of discontinuance; and
2356 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
2357 to reenroll.
2358 (c) At the time the eligible employee's coverage is discontinued under Subsection
2359 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
2360 coverage is discontinued.
2361 (d) An eligible employee may not be discontinued under this Subsection (6) because of
2362 a fraud or misrepresentation that relates to health status.
2363 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
2364 the employer:
2365 (a) with respect to coverage provided to an employer member of the association; and
2366 (b) if the small employer health benefit plan is made available by a covered carrier in
2367 the employer market only through:
2368 (i) an association;
2369 (ii) a trust; or
2370 (iii) a discretionary group.
2371 (8) A covered carrier may modify a small employer health benefit plan only:
2372 (a) at the time of coverage renewal; and
2373 (b) if the modification is effective uniformly among all plans with that product.
2374 Section 15. Section **31A-30-112** is amended to read:
2375 **31A-30-112. Employee participation levels.**
2376 (1) (a) Except as provided in Subsection (2) of this section and Subsection 31A-30-
2377 202(3), a requirement used by a covered carrier in determining whether to provide coverage to
2378 a small employer, including a requirement for minimum participation of eligible employees

*** PROTECTED ***

2379 and minimum employer contributions, shall be applied uniformly among all small employers
2380 with the same number of eligible employees applying for coverage or receiving coverage from
2381 the covered carrier.

2382 (b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require
2383 that a small employer have a minimum of two eligible employees to meet participation
2384 requirements.

2385 (2) A covered carrier may not increase a requirement for minimum employee
2386 participation or a requirement for minimum employer contribution applicable to a small
2387 employer at any time after the small employer is accepted for coverage.

2388 Section 16. Section **31A-30-201** is enacted to read:

2389 **Part 2. Defined Contribution Arrangements**

2390 **31A-30-201. Title.**

2391 This part is known as "Defined Contribution Arrangements".

2392 Section 17. Section **31A-30-202** is enacted to read:

2393 **31A-30-202. Definitions.**

2394 For purposes of this part:

2395 (1) "Section 125 plan" means a plan that qualifies under Section 125 of the Internal
2396 Revenue Code which permits an employee to contribute pre-tax dollars to a health benefit plan;
2397 and

2398 (2) "Self-funded plan" means a health benefit plan that:

2399 (a) is not subject to regulation by this state or any other state;

2400 (b) is paid in whole or in part from:

2401 (i) the employer's assets; or

2402 (ii) from a funded welfare benefit plan; and

2403 (c) except for reinsurance or stop-loss coverage, does not shift any risk or liability for
2404 benefit payments to an insurer or other carrier.

2405 Section 18. Section **31A-30-203** is enacted to read:

2406 **31A-30-203. Insurer Requirements -- Employer responsibilities -- Self Funded**
2407 **Plans.**

2408 (1) An employer who chooses to establish a defined contribution arrangement to
2409 provide a health benefit plan for its employees shall:

2410 (a) establish a Section 125 plan;

2411 (b) offer its employees a choice of one or more health benefit plans available through
2412 the Internet portal created under Section 63M-1-2504;

2413 (c) automatically enroll an employee in a health benefit plan that is available through
2414 the Internet portal and, selected by the employer, if the employee does not:

2415 (i) select a different health benefit plan available through the Internet portal;

2416 (ii) provide proof of coverage from another health benefit plan; or

2417 (iii) specifically decline coverage through a health benefit plan available through the
2418 Internet portal.

2419 (2) An insurer who offers a health benefit plan for which an employer has established a
2420 defined contribution arrangement under the provisions of this part:

2421 (a) shall ~~not~~:

2422 (i) establish a small employer minimum contribution level for the health benefit
2423 premium under Section 31A-30-112, or any other law; or

2424 (ii) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to
2425 maintain a minimum employer contribution level;

2426 (b) shall accept premium payments for an enrollee from multiple sources, including:

2427 (i) government assistance programs;

2428 (ii) contributions from a Sec. 125 plan established by another employer of the enrollee;

2429 and

2430 (iii) contributions from a Sec. 125 plan established by an employer of a spouse or
2431 dependent of the enrollee; and

2432 (c) may require, as a condition of coverage, a minimum participation level for eligible
2433 employees of an employer.

2434 (3) A self-funded benefit plan or a large group health benefit plan may elect to
2435 participate in the defined contribution arrangements under this part and has the same rights,
2436 responsibilities, and obligations as other participating insurers.

2437 Section 19. Section **31A-30-204** is enacted to read:

2438 **31A-30-204. Rating restrictions for defined contribution arrangements -- Risk**
2439 **adjuster mechanism.**

2440 (1) Notwithstanding the provisions of Sections 31A-30-105 and 31A-30-106, an
2441 insurer who offers a health benefit plan in a defined contribution arrangement may base
2442 premium rates only on:

2443 (a) ~~age~~;

2444 (b) geography; and

2445 (c) family composition.

2446 (2) An insurer who offers a health benefit plan available through the Internet portal

2447 shall participate in the risk adjuster mechanism created by Chapter 42. Utah Health Re-

2448 Insurance Pool.

2449 Add a new section requiring the Health System Reform Oversight and Review Committee

2450 report to joint Health and Human Services and Business and Labor Interim Committees by

2451 October of each year including but not limited to: the number of employers participating, the

2452 number of covered lives, the median employer contribution, the median employee contribution,

2453 the number of employees who choose a plan different from the employer selected plan.

2454 Insurers are required to provide requested data...

2455 Section 20. Section **31A-42-101** is enacted to read:

2456 **CHAPTER 42. UTAH HEALTH RE-INSURANCE POOL**

2457 **Part 1. General Provisions**

2458 **31A-42-101. Title.**

2459 This chapter is known as the "Utah Health Re- Insurance Pool."

2460 Section 21. Section **31A-42-102** is enacted to read:

2461 **31A-42-102. Definitions.**

2462 As used in this chapter:

2463 (1) "Board" means the board of directors of the Utah Health Re-Insurance Pool created

2464 in part 2, Creation of Pool.

2465 (2) "COBRA" means:

2466 (a) the Consolidated Omnibus Budget Reconciliation Act of 1985; and

2467 (b) state mini-COBRA under Section 31A-22-722.

2468 (3) "Pool" means the Utah Health Re-Insurance Pool created by this act.

2469 (4) "Pool fund" means the Utah Health Re-insurance Pool Enterprise Fund created in

2470 Section 31A-42-211.

2471 (5) "Self funded health benefit plan" means a health benefit plan that:

2472 (a) is not subject to regulation by this state or any other state;

2473 (b) is paid in whole or in part by:

2474 (i) the employer from the employer's assets; or

2475 (ii) from a funded welfare benefit plan; and

2476 (c) except for re-insurance or stop-loss coverage, does not shift any risk or liability for

2477 benefit payments to an insurer or other carrier.

2478 Section 22. Section **31A-42-103** is enacted to read:

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2479 **31A-42-103. Applicability and scope.**

2480 (1) Except as provided in Subsection (2), this chapter applies to a carrier as defined in
2481 Section 31A-30-103 who offers a health benefit plan that provides coverage to:

- 2482 (a) (i) a small employer; or
- 2483 (ii) a large employer health benefit plan; and
- 2484 (b) regardless of whether the contract is issued to:
 - 2485 (i) an association;
 - 2486 (ii) a trust;
 - 2487 (iii) a discretionary group;
 - 2488 (iv) another similar grouping; or
 - 2489 (v) the situs of delivery of the policy or contract.

2490 (2) This chapter does not apply to:

- 2491 (a) individual policies;
- 2492 (b) short term limited duration health insurance; or
- 2493 (c) federally funded or partially funded programs.

2494 Section 23. Section **31A-42-201** is enacted to read:

Part 2. Creation of Pool

2496 **31A-42-201. Creation of Utah Health Re-Insurance Pool -- Board of directors --**
2497 **Appointment -- Terms -- Quorum -- Plan preparation.**

2498 (1) There is created the "Utah Health Re-Insurance Pool", a nonprofit entity within the
2499 Insurance Department.

2500 (2) The pool shall be under the direction of a board of directors composed of 12
2501 members.

2502 (a) The governor shall appoint eleven of the directors from carriers and insurance
2503 arrangements in the state with the consent of the Senate as follows:

- 2504 (i) there shall be no more than two members of the board who represent any one carrier
2505 or insurance arrangement; and
- 2506 (ii) the members selected shall be from:
 - 2507 (A) the small group market;

2508 (B) the large group market;
2509 (C) preferred provider group plans; and
2510 (D) health maintenance organizations.
2511 (b) The board shall also include the commissioner or the commissioner's designee.
2512 (3) (a) Except as required by Subsection (3)(b), as terms of current board members
2513 expire, the governor shall appoint each new member or reappointed member to a four-year
2514 term.
2515 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
2516 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
2517 board members are staggered so that approximately half of the board is appointed every two
2518 years.
2519 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
2520 appointed for the unexpired term in the same manner as the original appointment was made.
2521 (5) (a) (i) Members who are not government employees shall receive no compensation
2522 or benefits for the member's services, but may receive per diem and expenses incurred in the
2523 performance of the member's official duties at the rates established by the Division of Finance
2524 under Sections 63A-3-106 and 63A-3-107 from the pool fund.
2525 (ii) Members may decline to receive per diem and expenses for their service.
2526 (b) (i) State government officer and employee members who do not receive salary, per
2527 diem, or expenses from their agency for their service may receive per diem and expenses
2528 incurred in the performance of their official duties from the pool at the rates established by the
2529 Division of Finance under Sections 63A-3-106 and 63A-3-107.
2530 (ii) A state government member who is a member because of their state government
2531 position may not receive per diem or expenses for their service.
2532 (iii) State government officer and employee members may decline to receive per diem
2533 and expenses for their service.
2534 (6) The board shall elect annually a chair and vice chair from its membership.
2535 (7) Six board members are a quorum for the transaction of business.
2536 (8) The action of a majority of the members of the quorum is the action of the board.
2537 Section 24. Section **31A-42-202** is enacted to read:
2538 **31A-42-202. Contents of plan.**
2539 The board shall submit a plan of operation for the pool to the commissioner. The plan
2540 shall:
2541 (1) demonstrate that any and all assumptions of risk or liability by the pool shall be

*** PROTECTED ***

2542 based on sound financial and actuarial principles reviewed and established in advance by the
2543 board and approved by the commissioner;

2544 (2) establish procedures in compliance with Title 51, Chapter 7, State Money
2545 Management Act, and accounting policies and procedures established by the Division of
2546 Finance, for handling and accounting of assets and money of the pool;

2547 (3) establish regular times and places for meetings of the board;

2548 (4) establish procedures for keeping records of all financial transactions and for
2549 sending annual fiscal reports to the commissioner;

2550 (5) contain additional provisions necessary and proper for the execution of the powers
2551 and duties of the pool;

2552 (6) establish procedures to pay claims under the pool;

2553 (7) establish procedures in compliance with Title 63A, Utah Administrative Services
2554 Code, to pay for administrative expenses incurred;

2555 (8) establish the different types and kinds of risk that can be ceded to the pool by
2556 participating carriers;

2557 (9) for each type of kind of risk that may be ceded to the pool, establish the share of
2558 risk to be pooled and the terms for apportioning claims associated with the risk between the
2559 ceding carrier and the pool; and

2560 (10) establish the methodology for calculating and apportioning among participating
2561 carriers any assessments to cover losses incurred in the operation of the pool and the schedule
2562 for the assessments.

2563 Section 25. Section **31A-42-203** is enacted to read:

2564 **31A-42-203. Powers of board.**

2565 (1) The board shall have the general powers and authority granted under the laws of
2566 this state to insurance companies licensed to transact health insurance business, except the
2567 power to issue health benefit plans directly to either groups or individuals. In addition, the
2568 board shall have the specific authority to:

2569 (a) enter into contracts to carry out the provisions and purposes of this chapter,
2570 including, with the approval of the commissioner, contracts with:

2571 (i) similar pools of other states for the joint performance of common administrative
2572 functions; or

2573 (ii) persons or other organizations for the performance of administrative functions;
2574 (b) sue or be sued, including taking legal action necessary to:

2575 (i) avoid the payment of improper claims against the pool or the coverage provided
2576 through the pool; and

2577 (ii) recover any assessments for, on behalf of, or against members of the pool;
2578 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,
2579 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the
2580 operation of the pool;

2581 (d) define the type of health benefit plans for which re-insurance will be provided, in
2582 accordance with this chapter;

2583 (e) issue re-insurance policies in accordance with this chapter;

2584 (f) establish rules and conditions pertaining to the reinsurance of a participating
2585 carrier's risks by the pool;

2586 (g) assess participating carriers in accordance with Section 31A-42-208, and make
2587 interim assessments as may be reasonable and necessary for organizational and interim
2588 operating expenses;

2589 (h) retain an executive director and appropriate legal, actuarial, and other personnel as
2590 necessary to provide technical assistance in the operations of the pool;

2591 (i) cause the pool to have an annual audit of its operations by the state auditor;
2592 (j) provide for and employ cost containment measures and requirements for the
2593 purpose of making the pool more cost-effective;

2594 (k) establish annual limits on benefits payable under the pool to or on behalf of any
2595 participating carrier;

2596 (l) exclude from coverage under the pool specific benefits, medical conditions, and
2597 procedures for the purpose of protecting the financial viability of the pool;

2598 (m) administer the pool fund; and

2599 (n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
2600 Rulemaking Act, to implement this chapter.

2601 (2) (a) The board shall prepare and submit an annual report to the department for
2602 inclusion in the department's annual market report, which shall include:

2603 (i) the net premiums anticipated;
2604 (ii) actuarial projections of payments required of the pool;

2605 (iii) the expenses of administration;
2606 (iv) any assessments imposed under Section 31A-42-208; and
2607 (v) the anticipated reserves or losses of the pool; and-
2608 (vi) study the full impact of the new Reinsurance pool and make recommendations to
2609 improve it in conjunction with the Health System Reform Oversight and Review Committee.

2610 (b) The budget for operation of the pool is subject to the approval of the board.
2611 (c) The administrative budget of the board and the commissioner under this chapter
2612 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
2613 subject to review and approval by the Legislature.

2614 Section 26. Section **31A-42-204** is enacted to read:

2615 **31A-42-204. Powers of commissioner.**

2616 (1) The commissioner shall, after notice and hearing, approve the plan of operation if
2617 the commissioner determines that the plan:

2618 (a) will assure the fair, reasonable, and equitable administration of the pool; and
2619 (b) provides for the sharing of pool gains and losses on an equitable and proportionate
2620 basis.

2621 (2) The plan shall be effective upon the adoption of administrative rules in accordance
2622 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2623 (3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any
2624 time thereafter fails to submit proposed amendments to the plan of operation within a
2625 reasonable time after requested by the commissioner, the commissioner shall, after notice and
2626 hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

2627 (4) Rules promulgated by the commissioner shall continue in force until modified by
2628 the commissioner or until superseded by a subsequent plan of operation submitted by the board
2629 and approved by the commissioner.

2630 (5) The commissioner may designate an executive secretary from the department to
2631 provide administrative assistance to the board in carrying out its responsibilities.

2632 A new section should be added to regarding the Health System Reform Oversight and Review
2633 Committee reviewing claims and developing best practices.

2634 Section 27. Section **31A-42-205** is enacted to read:

2635 **31A-42-205. Examination -- Financial report.**

2636 (1) The pool is subject to examination by the commissioner.

2637 (2) By December 1 of each year, the board shall submit to the commissioner an audited
2638 financial report for the preceding fiscal year in a form approved by the commissioner.

2639 Section 28. Section **31A-42-206** is enacted to read:

2640 **31A-42-206. Pool administrator -- Selection -- Powers.**

2641 (1) The board shall select a pool administrator in accordance with Title 63G, Chapter
2642 6, Utah Procurement Code. The board shall evaluate bids based on criteria established by the
2643 board, which shall include:

2644 (a) proven ability to handle accident and health re-insurance;

2645 (b) efficiency of claim paying procedures;

2646 (c) underwriting;

2647 (d) an estimate of total charges for administering the pool; and

2648 (e) ability to administer the pool in a cost-efficient manner.

2649 (2) (a) The pool administrator shall serve for a period of five years, with two one-year
2650 extension options, subject to the terms, conditions, and limitations of the contract between the
2651 board and the administrator.

2652 (b) At least one year prior to the expiration of the contract between the board and the
2653 pool administrator, the board shall invite all interested parties, including the current pool
2654 administrator, to submit bids to serve as the pool administrator.

2655 (c) Selection of the pool administrator for a succeeding period shall be made at least
2656 six months prior to the expiration of the period of service under Subsection (2)(a).

2657 (3) The pool administrator is responsible for all operational functions of the pool and
2658 shall:

2659 (a) have access to all nonpatient specific experience data, statistics, treatment criteria,
2660 and guidelines compiled or adopted by the Medicaid program, the Public Employees Health
2661 Plan, the Department of Health, or the Insurance Department, and which are not otherwise
2662 declared by statute to be confidential;

2663 (b) perform all eligibility, enrollment, member agreements, and administrative claim
2664 payment functions relating to the pool;

2665 (c) establish, administer, and operate a monthly premium billing procedure for
2666 collection of premiums from reinsuring carriers;

2667 (d) perform all necessary functions to ensure timely payment of benefits to
2668 participating insurers, including:

2669 (i) making information available relating to the proper manner of submitting a claim
2670 for benefits to the pool administrator and distributing forms upon which submission shall be
2671 made; and

2672 (ii) evaluating the eligibility of each claim for payment by the pool;

2673 (e) submit regular reports to the board regarding the operation of the pool, the
2674 frequency, content, and form of which shall be determined by the board;

2675 (f) (i) following the close of each calendar year, determine net written and earned
2676 premiums, the expense of administration, and the paid and incurred losses for the year; and (ii)
2677 submit a report of the information required in this Subsection (f) to the board, the
2678 commissioner, and the Division of Finance on a form prescribed by the commissioner; and

2679 (g) be paid as provided in the plan of operation for expenses incurred in the
2680 performance of the pool administrator's services.

2681 Section 29. Section **31A-42-207** is enacted to read:

2682 **31A-42-207. Eligibility for pool membership and ceding risk.**

2683 (1) (a) Every carrier licensed to offer a health benefit plan in the state shall participate
2684 in the pool as a condition of its authority to transact business in the state if the carrier offers
2685 one or more of the following:

2686 (i) a group health plan as defined in Section 31A-1-301;

2687 (ii) continuation coverage under COBRA;

2688 (iii) health insurance to a large employer as defined in Section 31-1-301;

2689 (iv) a small employer plan under Chapter 30, Individual, Small Employer and Group
2690 Health Insurance Act; or

2691 (v) a health benefit plan offered through the Internet portal, in a defined contribution
2692 arrangement under Chapter 30, Part 2, Defined Contribution Arrangements.

2693 (b) Subsection (1)(a) does not apply to health benefit plans offered to an individual.

2694 (2) Notwithstanding the provisions of Subsection 31A-30-104(4)(c), a carrier may
2695 reinsure with the pool:

2696 (a) if the carrier offers a product through the Internet portal, under a defined
2697 contribution arrangement;

2698 ~~(b) for the enrollees in the products offered through the Internet portal under a defined~~
2699 ~~contribution arrangement; and~~

2700 (c) if the carrier complies with the provisions of this section.

2701 (3) (a) A self funded health benefit plan may elect to participate in the pool in
2702 accordance with this Subsection (3).

2703 (b) A self funded plan that elects to participate in the pool:

2704 (i) is a participating carrier for purposes of this act;

2705 (ii) has the same rights, privileges, responsibilities, and obligations as other
2706 participating carriers; and

2707 (iii) must contract with the plan administrator that for each of the three plan years
2708 immediately following the plan's withdrawal from the pool, the plan sponsor is subject to
2709 assessments by the pool under Section 31A-42-208 as if the plan were still a participating
2710 carrier in the pool.

2711 (4) (a) The pool shall reinsure the level of coverage provided in the carrier's health
2712 benefit plan and shall adjust premiums and assessments for the reinsurance based on that level
2713 of coverage.

2714 (b) A reinsuring carrier may reinsure:

2715 (i) an entire employer group within 60 days of the commencement of the group's
2716 coverage under a health benefit plan; or

2717 (ii) an eligible employee or dependent within a 60 day period following the
2718 commencement of the coverage with the employer.

2719 (5) The pool may reimburse a reinsuring carrier with respect to a claim of a reinsured
2720 enrollee or dependent:

2721 (a) if, in the aggregate, the amount of claims for an employee or a dependent in the
2722 plan year are \$5,000 or higher; and

2723 (b) if the reinsuring carrier maintains 20% of the risk of claims for the employee or
2724 dependent, up to a maximum of \$55,000 in claims for the employee or dependent for the plan
2725 year.

2726 (6) The board shall annually adjust the initial level of claims and the maximum limit to
2727 be retained by the reinsuring carrier to reflect increases in cost and utilization within the health
2728 benefit plans within the state.

2729 (7) A participating carrier may terminate re-insurance with the pool for one or more of
2730 the reinsured employees or dependents on any anniversary date of the health benefit plan.

2731 (8) A carrier who cedes risk to the pool shall apply all managed care and claims
2732 handling techniques, including utilization review, healthy behavior and wellness programs,
2733 individual case management, pharmacy provisions, and any other type of cost or quality
2734 control programs within a health benefit plan consistently among all enrollees of the health
2735 benefit plan, regardless of whether the enrollee is reinsured with the pool.

2736 Section 30. Section **31A-42-208** is enacted to read:

2737 **31A-42-208. Premiums -- Assessment for pool.**

2738 (1) (a) Premiums for reinsurance by the pool shall be assessed annually by the board
2739 according to the plan adopted by the board.

2740 (b) Premiums charged for reinsurance by the pool to a health maintenance organization

*** PROTECTED ***

2741 that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and is subject to federal limits
2742 on the amount of risk that can be ceded, may be modified by the board as necessary to comply
2743 with federal law.

2744 (2) If premiums or other receipts received by the pool exceed the amount required for
2745 the operation of the pool, including actual losses and administrative expenses, the board shall
2746 direct that the excess be held in the pool fund, or used to offset future losses, including reserves
2747 for incurred but not reported claims.

2748 (3) (a) A deficit shall be incurred by the pool when anticipated losses plus incurred but
2749 not reported claims expenses exceed anticipated income from earned premiums net of
2750 administrative expenses.

2751 (b) (i) A deficit incurred or expected to be incurred, shall be recovered from
2752 assessments on participating carriers in accordance with this section and the plan of operation
2753 adopted by the board.

2754 (ii) The assessment formula adopted by the board in its plan of operation shall apply to
2755 participating insurers as required by Subsection 31A-42-207(1), and shall be based on each
2756 participating carrier's share of the total premiums earned in the preceding calendar year for the
2757 health benefit plans delivered or issued in the state.

2758 (iii) Prior to March 1 of each year the board shall determine and file with the
2759 commissioner an estimate of the assessments needed to fund the losses incurred by the pool in
2760 the previous calendar year.

2761 (c) A participating carrier may petition the board for an abatement or deferment of all
2762 or part of an assessment. The board may abate or defer, in whole or in part, the assessment if,
2763 in the opinion of the board, payment of the assessment would endanger the ability of the
2764 participating carrier to fulfill its contractual obligations to pay covered claims. A participating
2765 carrier receiving a deferment shall remain liable to the pool for the deficiency.

2766 (d) A participating carrier may appeal a decision of the board to the commissioner in
2767 accordance with Title 63G, Chapter 4, Administrative Procedures Act.

2768 Section 31. Section **31A-42-209** is enacted to read:

2769 **31A-42-209. Enterprise fund.**

2770 (1) There is created an enterprise fund known as the Utah Health Re-Insurance Pool
2771 Enterprise Fund.
2772 (2) The following funds shall be credited to the pool fund:
2773 (a) appropriations from XXXXX;
2774 (b) pool policy premium payments;
2775 (c) assessments collected by the pool under Section 31A-42-208; and
2776 (d) all interest and dividends earned on the pool fund's assets.
2777 (3) All money received by the pool fund shall be deposited in compliance with Section
2778 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51,
2779 Chapter 7, State Money Management Act.
2780 (4) The pool fund shall comply with the accounting policies, procedures, and reporting
2781 requirements established by the Division of Finance.
2782 (5) The pool fund shall comply with Title 63A, Utah Administrative Services Code.