Section by Section Index on Proposed Legislation: *Health Reform Amendments (Rep. J. Dunnigan)*

Section 1 (line 85)
Health Care Delivery Demonstration Projects

- DOH and DOI coordinate to monitor progress of demonstration projects for HC delivery and payment reform
    - *periodically* convene HC providers, payers, consumers to this end

Section 2 (line 91)
Program Benefits

- Program benefits *may* include:
    - Hospital services
    - Physician services
    - Laboratory services
    - Prescription drugs
    - Mental health services
    - Basic dental health services
    - Preventive care including:
        - Routine physical
        - Immunizations
        - Basic vision
        - Basic hearing
        - Limited home health and durable equipment
        - Hospice
- Benefits shall be benchmarked to be actuarially equivalent to the health benefit plan with the largest insured commercial enrollment offered by an HMO in the state.
    - Not to exceed certain parameters (line 112)
    - To be adjusted every July 1 (line 114)
- Dental to be benchmarked re: CHIPRA
- Program benefits for enrollees ≤100%FPL are exempt from benchmark levels

Section 3 (line 123)
Insurers' authority and compliance with ACA+ ("Miscellaneous duties")

- When the commissioner revokes an insurer license in Utah, must inform that insurer's agents and may publish notice (protect the rights of the public).
- Commissioner furnishes a certificate of authority for insurers when needed in legal proceedings.
- Other items about insurers' certification or revocation thereof
- Commissioner requires that insurer complies with HIPAA, ACA, HCERA (Health Care Education Reconciliation Act) in regards to:
    - Lifetime and annual limits
    - Prohibition of rescissions
    - Coverage of preventive services

- Dependent coverage
- Pre-existing condition coverage for children
- Insurer transparency
- Premium rate reviews
- Essential benefits
- Provider choice
- Waiting periods
- Appeals processes

Section 4 (line 180)

- **Price and Value Comparisons of Health Insurance**
- "The commissioner shall promote informed consumer behavior and responsible health benefit plans…" (Line 185)
    - Insurer required to provide written disclosure of:
        - Rx (formulary, co-pays and deductibles, generics required)
        - Coverage limits
        - Limitations or exclusions
    - Insurer must provide the commissioner with:
        - Info described in subsections 31A-22-635(5) through (7)…
        - Information regarding insurer transparency
  - Insurers provide required disclosure in writing to commissioner:
    - upon commencement of operations in the state
    - anytime the insurer amends:
        - treatment policies
        - practice standards
        - restrictions
        - coverage limits
        - limitations of exclusions of coverage
  - Insurers provide enrollees with notice of increase of costs of Rx either in
    - in writing or on insurer's website
    - at least 30 days prior
  - If a formulary is used insurer must disclose to prospective enrollees
    - drugs included
    - patented drugs not included
    - conditions that exist as precedent to coverage
    - exclusions from coverage for secondary medical conditions that exist as result of using excluded drug
- Commissioner shall forward information to the Exchange and can request information from an insurer to verify information
- Commissioner shall
  - convene a "group" to develop information for consumers to compare health insurers and health benefit plans on the Exchange
    - Group:

                - Insurers
                - A member of PEHP
                - Consumers
                - And an organization described… (see line 252)
            - Group will consider the following:
                - Number and cost of an insurer's denied health claims
                - Cost of denied claims that is transferred to providers
                - Average out-of-pocket expenses incurred by participants in each health benefit plan that is offered by an insurer on the Exchange
                - Relative efficiency and quality of claims administration and other admin processes for each insurer on the Exchange
                - Consumer assessment of each insurer or health benefit plan
    - Adopt administrative rule to
        - Define terms
        - Methodology for determining and comparing the insurer transparency information
        - Data and its format that insurer must submit to commissioner to facilitate consumer comparison on Exchange
        - Dates on which said data must be submitted
    - Implement rules in a way that protects business confidentiality of the consumer

Section 5 (line 275)

HC Delivery and Payment Reform Demonstration Projects

- DOH, Commissioner, Speaker of the House, President of Senate, all can/shall be involved in facilitating such.

Section 6 (line 317)

Uniformity on Health Insurance Exchange

- Insurers to individuals & small employees
    - must use a short/simple uniform application form:
        - may not include questions about health history prior to past 10 years (except cancer and transplant)
    - must use a uniform waiver of coverage
        - cannot include health status related questions, except pregnancy
        - is limited to:
            - information that identifies employee
            - proof of the employee's insurance coverage
            - a statement that the employee declines coverage with a particular employer group
    - uniform application and waiver forms may be combined or modified to facilitate a more efficient and consumer-friendly shopping experience
- Insurers to large groups must also use uniform application and wavier forms

- These uniform forms must be approved by the commissioner
- Insurers in the Exchange must
    - Accept and process applications/waivers electronically
    - Provide applicant with an electronic or paper copy if requested
    - Post info about plans and benefits on the Exchange
    - Not offer any thing that is not a benefit plan on the Exchange
- Insurers must post the following on the Exchange:
    - Plan design, benefits, options including state mandates the plan does not cover
    - Provider networks
    - Wellness programs and incentives
    - Descriptions of Rx benefits, exclusions, limitations
    - % claims paid by the insurer within 30 days of date claim is submitted for previous year
    - Claims denial and insurance transparency info required by Section… (line 385)
- DOI must post (on Exchange) the solvency rating of insurers on Exchange.
    - Solvency rating based on DOI methodology
    - Updated every year
- Commissioner
    - May request data from insurer for validation of said information
    - Shall regulate any fees charged by insurers to enrollees for uniform application form and/or electronic submission of forms

Section 7 (line 399)

Utah NetCare Plan (alternative –to COBRA—coverage)

- Definition of alternative coverage
- Utah NetCare must include
    - Healthy lifestyle and wellness incentives
    - Benefits described in this subsection (2) or at least the actuarial equivalent of them
    - Requirements for max. benefits, deductibles, out-of-pocket max costs
    - Required benefits BEFORE applying a deductible:
        - Preventive care
        - Primary car e and specialist and urgent care (with limitations) up to $300 annual maximum before you reach deductible
        - Supplemental accident coverage up to $500 annual max
    - Co-pays
- Utah NetCare can exclude:
    - Benefit mandates described in Subsections (line 465)
    - (unless required by federal law) mandates for adoption indemnity, inborn errors of metabolism, primary care physician, coverage of diabetes, mandated coverage enacted after 1/1/09 (see lines 466+)
- Utah NetCare may include formulary or preferred drug list
- Who can elect “alternative” coverage, including spouse/dependent
- Insurer may not use a risk factor greater than the employer’s most current risk factor

Section 8 (line 511)
Appointment of individual and agency insurance producer, limited line producer, or managing general agent.

Section 9 (line 547)
Use of Customer Service Representative

- Customer service representative
    - May not maintain an office independent of its licensed producer or consultant employer for the purpose of conducting insurance activities
    - Does not have the authority to sell, solicit, negotiate, or bind coverage

Section 10 (line 554)
Representations of Agency

- Can only act on behalf of insurer if written agency contract
- Producers appointed to the Exchange are not prohibited from assisting consumers/employers with enrolling in the exchange, or with selecting a benefit plan offered on the Exchange

Section 11 (line 563)
Definitions

Section 12 (line 643)
Definitions

Section 13 (line 753)
Applicability and Scope

Section 14 (line 822)
Actuarial Review of Health Benefit Plans

- The department shall conduct an actuarial review of rates submitted by small employer carriers
    - Prior to publication of premium rates on the Exchange
    - To determine if rates are in compliance with… (see line826)
    - To verify validity of rates, underwriting and risk factors, and premiums of plans both IN and OUT of Exchange.
    - As the dept sees necessary to oversee market conduct
- Review funded by a fee paid by all small employer carriers… into a created "Health Insurance Actuarial Review Restricted Account"
- Department will report info in aggregate and contact individual carriers where there are concerns.

Section 15 (line 854)

Health Benefit Plans Offered in the Defined Contribution Market

- Small group market plans offered by insurers must include at least
    - One federally qualified high deductible health plan (one standard for before 1/1/11 and another for on or before 1/1/12) (see lines 859 and 871)
    - One health benefit plan with an aggregate actuarial value of at least 15% greater than the actuarial value of the benefit plan described in subsection (1)(a)
    - The insurers four most commonly selected benefit plans that
        - Include
            - The provider panel
            - The deductible
            - Co-payments
            - Co-insurance
            - Rx benefits
        - Are currently being marketed to new groups for enrollment
    - Small group market CAN OFFER more plans as long as each plan's aggregate actuarial value is no lower than the value of the plan required in subsection (1)(c)
- Large group market plan offered by insurers must include at least
    - One federally qualified high deductible plan
    - The insurer's four most commonly selected large group benefit plans as determined by the commissioner by administrative rule
    - Can offer other plans that comply with subsection (2)

Section 16 (line 902)

Contents of Plan of Operation for the Risk Adjustor

- Plan will establish
    - methodology for implementing defined contribution arrangements etc.
    - regular meeting times/places for the meetings of the board
    - record keeping procedure for all financial transactions/fiscal reports
    - and other as needed
- Plan will include
    - Parameters an employer may use to designate eligible employees for the defined contribution arrangement market
    - Underwriting mechanisms and employer eligibility guidelines consistent with HIPAA and necessary to protect insurers from adverse selection
- Plan will outline
    - how premium rates for a qualified individual are determined
        - Initial rate
            - Standardized age bands
            - Wellness incentives
        - Group risk factor
    - How premiums will be submitted to the Exchange and distributed to the insurers
    - A mechanism for adjusting risk between insurers (see line 942+)

- The board may amend the plan to
    - Incorporate large groups
    - Maintain proper functioning and solvency of the defined contribution market and the risk adjuster mechanism
    - Mitigate significant issues of risk selection
    - Improve administration of the risk adjuster mechanism
- The board will establish a mechanism for participating carriers to submit their plan base rates, rating factors, and premiums to the commissioner for an actuarial review prior to publications of premium rates on the exchange.

Section 17 (line 990)

List of non-lapsing funds and accounts

- Appropriations for the Health Insurance Actuarial Review Restricted Account.
- Plus many others

Section 18 (line 1011)

Creation of OCHS

- OCHS in cooperation with DOI, DOH, DWFS will
    - create Health Insurance Exchange that
        - Provides information to consumers about private and public health programs for which they may quality
        - Provides comparison of and enrollment in health insurance programs posted on Exchange
        - Includes information and a link to enrollment in premium assistance programs and other government assistance programs.
    - contract with private vendors for
        - administration of enrollment etc. on Exchange.
        - Establishment of call center
            - Provide unbiased answers to questions concerning exchange operations and plan information to the extent that info is on Exchange
            - But not sell, solicit, or negotiate insurance without using an insurance producer
    - assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars.
    - establish a list on the Exchange of appointed insurance producers
    - report to the Business and Labor Interim Committee and Health System Reform Task force prior to the legislative interim day (Nov) every year.
- OCHS
    - may not
        - Regulate health insurers, health insurance plans, or health insurance producers
        - Adopt administrative rules

        - Act as an appeals entity
    - May
        - Establish and collect a fee (see lines 1066+)

Section 19 (line 1075)

Insurer Transparency: Health Benefit Plan Information on the Health Insurance Exchange

- OCHS shall establish administrative rules for uniform electronic standards for insurers, employers, brokers, consumers, and vendors, to use when transmitting or receiving information, uniform applications or waivers of coverage, or payments to, or from the Health Insurance Exchange.
    - Rules shall promote an efficient and consumer friendly process for shopping for an enrolling in a health benefit plan offered on the Exchange
- OCHS shall assist the Risk Adjuster Board with determination of when an employer is eligible to participate in the Exchange under Defined Contribution Arrangements
- OCHS shall create an advisory board to advise the Exchange concerning the operation of the exchange, the consumer experience on the exchange, and transparency issues:
    - Two health producers
    - Two consumers
    - One representative of a large insurer
    - One representative of a small insurer
    - One representative from DOI
    - One from DOH
- All this information shall be posted on Exchange

Section 20 (line 1173)

Health System Reform Task Force

- Task Force
    - 11 members
        - 4 members of Senate (appointed by president of Senate): no more than 3 of same political party
        - 7 members of the House (appointed by Speaker): no more than 5 of same party
    - Co-chaired by on Senator and one Congressman
    - Must comply with rules of legislative interim committees
    - Salaries and expenses
    - Staff support from Office of Legislative Research and General Counsel

Section 21 (line 1193)

Task Force Duties: Interim Report

- Task force will review and make recommendations on the following:
    - State's response to federal health care reform, including whether we should have an Exchange in compliance with ACA
    - Legislation necessary to implement

        - Governance structure for Exchange as an independent state agency etc.
        - Operational blueprint for Exchange to promote and appropriate private/public balance
    - Should Exchange be modified to qualify as a SHOP Exchange under ACA?
    - Which market regulatory functions should be given to the Exchange which should remain with DOI, DOH, or DWFS
    - Policy and guidance about Exchange including consumer experience and transparency and cost information
    - Whether risk adjuster mechanism should be modified in response to ACA
    - Health care cost containment issues
        - Progress on demonstration projects
        - Effective tools for reducing costs of malpractice
- Final report for any proposed legislation presented to Health and Human Services Interim Committee before Nov 30 2011.

Section 22 (line 1225)
Intent language regarding lapsing of money