# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | **Technical change:** Formatting, numbering, word order, or language changes; no change in intent or practice;<br>**Codifying existing practice:** New or changed language, no change in practice;<br>**Policy Change:** New language, new practice. | |
|---|---|---|
| **Lines** | **Cite Change** | **Effect / Benefits** |
| | **31A-1-301 – Definitions** | |
| | (87) "Insurance adjuster" means a person who directs or handles the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.<br><br>(107) "Limited lines authority" includes [~~:~~<br>~~(a)~~] the lines of insurance listed in Subsection (106) [~~; and~~<br>~~(b) a customer service representative~~].<br><br>(145) "Rebating" means a partial refund or return of premium from the premium paid, commission paid, or consultant fee paid, directly or indirectly, on the sale or renewal of an insurance policy.<br><br>(150) "Resident" for the purpose of a resident insurance license in this state, means an individual who:<br>(a) owns real property, or<br>(b) resides the majority of the past twelve months in this state.<br><br>[~~(158)~~] (160) "Small employer [~~,~~]" means in connection with a health benefit plan [~~, means an employer who,~~] with respect to a calendar year and to a plan year, an employer who:<br>(a) employed an average of at least [~~two employees~~] one employee but not more than 50 eligible employees on [~~each~~] business days during the preceding calendar year; and<br>(b) employs at least [~~two employees~~] one employee on the first day of the plan year.<br><br>(169) "Tying of products" means the selling of one insurance product only when the purchase of another product is also required to be purchased. "Tying of products" does not mean the bundling of products to create a discounting of products, where either product can be purchased separately.<br><br>(2) An insurance fraud investigator employed pursuant to Subsection (1) may be designated a [~~special function~~] law enforcement officer, as defined in Section 53-13-10 [~~5~~]3, by the commissioner, but is not eligible for retirement benefits under the Public Safety Employee's Retirement System. | **Technical change:**<br>**Codifying existing practice:**<br>**Policy change:**<br><br>**Codifying existing practice:** The Affordable Care Act (ACA) requires the definition of small employer to include an employer who employees at least one employee for purposes of health insurance. |
| | **31A-3-304. (Superseded 07/01/15). Annual fees – Other taxes or fees prohibited – Captive Insurance Restricted Account.** | |
| | (4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June [~~20~~]1 of each year. | |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | **31A-3-304. (Effective 07/01/15). Annual fees – Other taxes or fees prohibited – Captive Insurance Restricted Account.** | |
| | (4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June [~~20~~]1 of each year. | |
| | **31A-4-102. Qualified insurers.** | |
| | (1) A person may not conduct an insurance business in Utah in person, through an agent, through a broker, through the mail, or through another method of communication, except:<br>(a) an insurer:<br>(i) authorized to do business in Utah under Chapter 5, 7, 8, 9, 10, 11, 13, [~~or~~] 14[~~;~~] 37, or 37a; and<br>(ii) within the limits of its certificate of authority;<br>(b) a joint underwriting group under Section 31A-2-214 or 31A-20-102;<br>(c) an insurer doing business under Section 31A-15-103;<br>(d) a person who submits to the commissioner a certificate from the United States Department of Labor, or such other evidence as satisfies the commissioner, that the laws of Utah are preempted with respect to specified activities of that person by Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law; or<br>(e) a person exempt from this title under Section 31A-1-103 or another applicable statute.<br>(2) As used in this section, "insurer" includes a bail bond surety company, as defined in Section 31A-35-102. | |
| | **31A-4-115. Plan of orderly withdrawal.** | |
| | (2) An insurer's plan of orderly withdrawal shall:<br>(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and<br>(b) include provisions for:<br>(i) meeting the insurer's contractual obligations;<br>(ii) providing services to its Utah policyholders and claimants;<br>(iii) meeting any applicable statutory obligations; and<br>(iv)[~~(A)~~] the payment of a withdrawal fee of $50,000 [~~to the Utah Comprehensive Health Insurance Pool if:<br>(I) the insurer is an accident and health insurer; and<br>(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner; or<br>(B) the payment of a withdrawal fee of $50,000~~ ]to the department if[~~:<br>(I) the insurer is not an accident and health insurer; and<br>(II)~~] the insurer's line of business is not assumed or placed with another insurer approved by the commissioner. | **Policy change:** the Utah Comprehensive Health Insurance Pool is closing enrollment as of 1/1/2014 as a result of the ACA. The change requires a health insurer to pay the withdrawal fee to the department, as with all other insurers, rather than HIPUtah. |
| | **31A-17-607. Hearings.** | |
| | (1) (a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge any determination or action by the commissioner.<br>(b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under Subsection[~~s 31A-17-604(1),~~](2)[~~, and (3)~~]. | |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | (c) Upon receipt of the insurer's or health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's or health organization's request. | |
| | **31A-22-428. Interest payable on life insurance proceeds.** | |
| | (2) (a) Except as provided in Subsection (4), for the period beginning on the date of death and ending the day before the day described in Subsection (3)(b), interest under Subsection (1) shall accrue at a rate no less than the greater of:<br>(i) the rate applicable to policy funds left on deposit; [~~or~~] and<br>(ii) [~~if there is no rate described in Subsection (2)(a)(i), at~~] the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve.<br>(b) If there is no rate applicable to policy funds on deposit as stated in Subsection (2)(a)(i), then the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve shall apply. | |
| | **31A-22-605.1. Preexisting condition limitations.** | |
| | (4) (a) Except as provided in this Subsection (4) and Subsection (5), a health benefit plan, issued or renewed prior to January 1, 2014, may impose a preexisting condition exclusion only if:<br>(i) the exclusion relates to a preexisting condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date from an individual licensed or similarly authorized to provide those services under state law and operating within the scope of practice authorized by state law;<br>(ii) the exclusion period ends no later than 12 months after the enrollment date, or in the case of a late enrollee, 18 months after the enrollment date; and<br>(iii) the exclusion period is reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection (4)(b).<br>(b) (i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is determined by counting all the days on which the individual has one or more types of creditable coverage.<br>(ii) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.<br>(A) Days in a waiting period or affiliation period are not taken into account in determining whether a significant break in coverage has occurred.<br>(B) For an individual who elects federal COBRA continuation coverage during the second election period provided under the federal Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.<br>(c) A group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy.<br>(d) (i) An insurer imposing a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion as part of any written application materials.<br>(ii) The general notice shall include:<br>(A) a description of the existence and terms of any preexisting condition exclusion under the plan, including the six-month period ending on the enrollment date, the maximum preexisting condition exclusion period, and how the insurer will reduce the maximum preexisting condition exclusion period by creditable coverage;<br>(B) a description of the rights of individuals: | **Codifying existing practice:** The Affordable Care Act (ACA) prohibits preexisting condition limitations on major medical plans offered on or after January 1, 2014. |

| | | |
|---|---|---|
| | (I) to demonstrate creditable coverage, including any applicable waiting periods, through a certificate of creditable coverage or through other means; and<br>(II) to request a certificate of creditable coverage from a prior plan;<br>(C) a statement that the current plan will assist in obtaining a certificate of creditable coverage from any prior plan or issuer if necessary; and<br>(D) a person to contact, and an address and telephone number for the person, for obtaining additional information or assistance regarding the preexisting condition exclusion.<br>(e) An insurer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.<br>(f) This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under the plan.<br>(5) For a health benefit plan issued or renewed on or after January 1, 2014, an insurer may not impose a preexisting condition exclusion. | |
| | **31A-22-617. Preferred provider contract provision.** | |
| | (1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.<br>(a) (i) A health care provider contract [~~may~~ ]shall require the health care provider to accept the specified payment in this Subsection (1) as payment in full, relinquishing the right to collect additional amounts from the insured person.<br>(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.<br>(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.<br>(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.<br>(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.<br>(b) The insurance contract may reward the insured for selection of preferred health care providers by:<br>(i) reducing premium rates;<br>(ii) reducing deductibles;<br>(iii) coinsurance;<br>(iv) other copayments; or<br>(v) any other reasonable manner.<br>(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f): | **Codifying existing practice:** The change from "may" to "shall" is consistent with industry practice. Health insurance enrollees who utilize an insurers contracted providers should only be responsible for the rate contracted between the provider and the insurer, rather than the provider's billed rate. |

| | | |
|---|---|---|
| | (i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:<br>(A) require the health care provider to continue to provide health care services under the contract until the earlier of:<br>(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or<br>(II) the date the term of the contract ends; and<br>(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);<br>(ii) the provider is required to:<br>(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and<br>(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);<br>(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:<br>(A) sums owed by the insolvent managed care organization; or<br>(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);<br>(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):<br>(A) a provider;<br>(B) an agent;<br>(C) a trustee; or<br>(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and<br>(v) notwithstanding Subsection (1)(c)(i):<br>(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and<br>(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:<br>(I) a petition for rehabilitation; or<br>(II) a petition for liquidation.<br>(9) [~~Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.~~<br>~~(10)~~ ] Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.<br>[~~(11)~~](10) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.<br>[~~(12)~~](11) Notwithstanding the provisions of Subsection (1), Subsection (7)(b), and Section 31A-22-618, an insurer or third party administrator is not required to, but may, enter into contracts with licensed athletic trainers, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act. | **Technical change:** Due to proposed changes to 31A-22-618.5 this section is no longer required. |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | **31A-22-618. Nondiscrimination among health care professionals.** | |
| | (1) Except as provided under Section 31A-22-617, and except as to [~~insurers~~ ]limited health plans licensed under Chapter 8, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition falls within the coverage of the contract. Upon the written request of an insured alleging an insurer has violated this section, the commissioner shall hold a hearing to determine if the violation exists. The commissioner may consolidate two or more related alleged violations into a single hearing. | **Codifying existing practice:** Effective January 1, 2014, the ACA prohibits an insurer from discriminating against health care professionals for health insurers, including health maintenance organizations. |
| | **31A-22-618.5. Health benefit plan offerings.** | |
| | (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans[~~:~~<br>~~(a)~~], notwithstanding Subsection 31A-22-617(9), may offer a health benefit plan that is not subject to [~~Section 31A-22-618;~~<br>~~(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and~~<br>~~(c) is not subject to~~ ]coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009. | **Codifying existing practice:** Effective January 1, 2014, the ACA prohibits an insurer from discriminating against health care professionals for health insurers, including health maintenance organizations. |
| | **31A-22-625. Catastrophic coverage of mental health conditions.** | |
| | (3)(a) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.<br>(b) An insurer shall provide in an individual or small employer health benefit plan, mental health and substance use disorder benefits in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.<br>(4) (a) [~~An.~~ ]For policies issued or renewed prior to January 1, 2014, an insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.<br>(b) (i) Notwithstanding any other provision of this title, an insurer may:<br>(A) establish a closed panel of providers for catastrophic mental health coverage; and<br>(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:<br>(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and<br>(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.<br>(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.<br>(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.<br>(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be | **Codifying existing practice:** Effective January 1, 2014, the ACA requires health care insurance policies to comply with the parity requirements of federal Mental Health and Substance Abuse Parity Act. |

| | | |
|---|---|---|
| | rendered:<br>(i) by a mental health therapist as defined in Section 58-60-102; or<br>(ii) in a health care facility:<br>(A) licensed or otherwise authorized to provide mental health services pursuant to:<br>(I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or<br>(II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and<br>(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.<br>(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.<br>[~~(6) The commissioner shall:~~<br>~~(a) adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section; and~~<br>~~(b) provide general figures on the percentage of insurance policies that include:~~<br>~~(i) no mental health coverage;~~<br>~~(ii) 50/50 mental health coverage;~~<br>~~(iii) catastrophic mental health coverage; and~~<br>~~(iv) coverage that exceeds the minimum requirements of this section.~~<br>~~(7) This section may not be construed as discouraging or otherwise preventing an insurer from providing mental health coverage in connection with an individual insurance policy.~~] | |
| | **31A-22-635. Uniform application – Uniform waiver of coverage – Information on Health Insurance Exchange.** | |
| | (1) For purposes of this section, "insurer":<br>(a) is defined in Subsection 31A-22-634(1); and<br>(b) includes the state employee's risk pool under Section 49-20-202.<br>(2) (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.<br>(b) The uniform application form~~:~~<br>~~(i) except for cancer and transplants,~~ may not include questions about an applicant's health history ~~prior to the previous five years;~~ and<br>~~(ii)~~ shall be shortened and simplified in accordance with rules adopted by the commissioner.<br>(c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions ~~other than pregnancy,~~ and is limited to:<br>(i) information that identifies the employee;<br>(ii) proof of the employee's insurance coverage; and<br>(iii) a statement that the employee declines coverage with a particular employer group.<br>(3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for:<br>(a) enrollees using the Health Insurance Exchange; or<br>(b) insurers using electronic applications. | **Codifying existing practice:** Effective January 1, 2014, the ACA prohibits insurers from collecting health information and rating policies based on health status. |

| | | |
|---|---|---|
| | (4) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.<br>(5) (a) An insurer who offers a health benefit plan [~~in either the group or individual market~~] on the Health Insurance Exchange created in Section 63M-1-2504, shall:<br>(i) accept and process an electronic submission of the uniform application or uniform waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to Section 63M-1-2506;<br>(ii) if requested, provide the applicant with a copy of the completed application either by mail or electronically;<br>(iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and<br>(iv) post the information required by Subsection (6) on the Health Insurance Exchange for every health benefit plan the insurer offers on the Health Insurance Exchange.<br>(b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans on the Health Insurance Exchange may not directly or indirectly offer products on the Health Insurance Exchange that are not health benefit plans.<br>(c) Notwithstanding Subsection (5)(b):<br>(i) an insurer may offer a health savings account on the Health Insurance Exchange; and<br>(ii) an insurer may offer dental ~~and vision~~ plans on the Health Insurance Exchange~~. if:~~<br>~~(A) the department determines, after study and consultation with the Health System Reform Task Force, that the department is able to establish standards for dental and vision policies offered on the Health Insurance Exchange, and the department determines whether a risk adjuster mechanism is necessary for a defined contribution vision and dental plan market on the Health Insurance Exchange; and~~<br>~~(B) the~~ (iii) The department~~, in accordance with recommendations from the Health System Reform Task Force, adopts~~ may adopt administrative rules to regulate the offer of dental ~~and vision~~ plans on the Health Insurance Exchange. | |
| | **31A-23a-102. Definitions.** | |
| | (5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person shall:<br>(i) file an application for an initial or renewal agency license with the commissioner on forms and in a manner the commissioner prescribes; and<br>(ii) pay a license fee that is not refunded if the application:<br>(A) is denied; or<br>(B) is incomplete when filed and is never completed by the applicant.<br>(b) An application described in Subsection (5)(a) shall provide:<br>(i) information about the applicant's identity;<br>(ii) the applicant's federal employer identification number;<br>(iii) the designated responsible licensed [~~producer~~] individual;<br>(iv) the identity of the owners, partners, officers, and directors;<br>(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and<br>(vi) any other information the commissioner reasonably requires. | |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | **31A-23a-105. General requirements for individual and agency license issuance and renewal.** | |
| | (1) (a) The commissioner shall issue or renew a license to a person described in Subsection (1)(b) to act as:<br>(i) a producer;<br>(ii) a surplus lines producer;<br>(iii) a limited line producer;<br>(iv) a consultant;<br>(v) a managing general agent; or<br>(vi) a reinsurance intermediary.<br>(b) The commissioner shall issue or renew a license under Subsection (1)(a) to a person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:<br>(i) satisfies the application requirements under Section 31A-23a-104;<br>(ii) satisfies the character requirements under Section 31A-23a-107;<br>(iii) satisfies any applicable continuing education requirements under Section 31A-23a-202;<br>(iv) satisfies any applicable examination requirements under Section 31A-23a-108;<br>(v) satisfies any applicable training period requirements under Section 31A-23a-203;<br>(vi) if an applicant for a resident individual producer license, certifies that, to the extent applicable, the applicant:<br>(A) is in compliance with Section 31A-23a-203.5; and<br>(B) will maintain compliance with Section 31A-23a-203.5 during the period for which the license is issued or renewed;<br>(vii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23a-111;<br>(viii) if a nonresident:<br>(A) complies with Section 31A-23a-109; and<br>(B) holds an active similar license in that person's <u>home</u> state[~~ of residence~~];<br>(ix) if an applicant for an individual title insurance producer or agency title insurance producer license, satisfies the requirements of Section 31A-23a-204;<br>(x) if an applicant for a license to act as a life settlement provider or life settlement producer, satisfies the requirements of Section 31A-23a-117; and<br>(xi) pays the applicable fees under Section 31A-3-103. | |
| | **31A-23a-108. Examination requirements.** | |
| | (1) (a) The commissioner may require applicants for any particular license type under Section 31A-23a-106 to pass a line of authority examination as a requirement for a license, except that an examination may not be required of applicants for:<br>(i) licenses under Subsection 31A-23a-106(2)(c); or<br>(ii) other limited line license lines of authority recognized by the commissioner or the Title and Escrow Commission by rule as provided in Subsection 31A-23a-106 (3).<br>(b) The examination described in Subsection (1)(a):<br>(i) shall reasonably relate to the line of authority for which it is prescribed; and<br>(ii) may be administered by the commissioner or as otherwise specified by rule.<br>(2) The commissioner shall waive the requirement of an examination for a nonresident applicant who:<br>(a) applies for an insurance producer license in this state <u>within 90 days of establishing legal residence in this state</u>; | |

| | | |
|---|---|---|
| | (b) has been licensed for the same line of authority in another state; and<br>(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or<br>(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:<br>(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or<br>(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.<br>[~~(3) A nonresident producer licensee who moves to this state and applies for a resident license within 90 days of establishing legal residence in this state shall be exempt from any line of authority examination that the producer was authorized on the producer's nonresident producer license, except where the commissioner determines otherwise by rule.~~]<br>[~~(4)~~] (3) This section's requirement may only be applied to applicants who are natural persons. | |
| | **31A-23a-112. Probation – Grounds for revocation.** | |
| | (1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:<br>(a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-23a-111; or<br>(b) at the issuance or renewal of a [~~new~~] license:<br>(i) with an admitted violation under 18 U.S.C. Sections 1033 [~~and~~] or 1034; or<br>(ii) with:<br>(A) a response to background information questions on a new or renewal license application ~~[indicating that:~~] that indicates; or<br>(B) information received from a background check conducted in connection with a new or renewal license application that indicates:<br>[~~(A)~~] (I) the person has been convicted of a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;<br>[~~(B)~~] (II) the person is currently charged with a crime, that is listed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication is withheld;<br>[~~(C)~~] (III) the person has been involved in an administrative proceeding regarding any professional or occupational license; or<br>[~~(D)~~] (IV) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.<br>(2) The commissioner may place a licensee on probation for a specified period no longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. Sections 1033 and 1034.<br>(3) The probation order shall state the conditions for retention of the license, which shall be reasonable.<br>(4) Any violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act. | |
| | **31A-23a-113. License lapse and voluntary surrender.** | |

| | | |
|---|---|---|
| | (1) (a) A license issued under this chapter shall lapse if the licensee fails to:<br>(i) pay when due a fee under Section 31A-3-103;<br>(ii) complete continuing education requirements under Section 31A-23a-202 before submitting the license renewal application;<br>(iii) submit a completed renewal application as required by Section 31A-23a-104;<br>(iv) submit additional documentation required to complete the licensing process as related to a specific license type or line of authority; or<br>(v) maintain an active license in a [~~resident~~] licensee's home state if the licensee is a nonresident licensee.<br>(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):<br>(A) military service;<br>(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or<br>(C) some other extenuating circumstances, such as long-term medical disability.<br>(ii) A licensee described in Subsection (1)(b)(i) may request:<br>(A) reinstatement of the license no later than one year after the day on which the license lapses; and<br>(B) waiver of any of the following imposed for failure to comply with renewal procedures:<br>(I) an examination requirement;<br>(II) reinstatement fees set under Section 31A-3-103;<br>(III) continuing education requirements; or<br>(IV) other sanction imposed for failure to comply with renewal procedures.<br>(2) If a license issued under this chapter is voluntarily surrendered, the license or line of authority may be reinstated:<br>(a) during the license period in which the license is voluntarily surrendered; and<br>(b) no later than one year after the day on which the license is voluntarily surrendered.<br>[~~(3) A voluntarily surrendered license that is reinstated during the license period set forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the license complies with any applicable continuing education requirements for the period during which the license was voluntarily surrendered.~~] | |
| | **31A-23a-203. Training period requirements.** | |
| | (1) A producer is eligible to become a surplus lines producer only if the producer:<br>(a) has passed the applicable surplus lines producer examination;<br>(b) has been a producer with property [~~and~~] or casualty or both lines of authority for at least three years during the four years immediately preceding the date of application; and<br>(c) has paid the applicable fee under Section 31A-3-103.<br>(2) A person is eligible to become a consultant only if the person has acted in a capacity that would provide the person with preparation to act as an insurance consultant for a period aggregating not less than three years during the four years immediately preceding the date of application.<br>(3) (a) A resident producer with an accident and health line of authority may only sell long-term care insurance if the producer:<br>(i) initially completes a minimum of three hours of long-term care training before selling long-term care coverage; and<br>(ii) after completing the training required by Subsection (3)(a)(i), completes a minimum of three hours of long-term care | |

| | | |
|---|---|---|
| | training during each subsequent two-year licensing period.<br>(b) A course taken to satisfy a long-term care training requirement may be used toward satisfying a producer continuing education requirement.<br>(c) Long-term care training is not a continuing education requirement to renew a producer license.<br>(d) An insurer that issues long-term care insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells long-term care insurance coverage is in compliance with this Subsection (3).<br>(4) The training periods required under this section apply only to an individual applying for a license under this chapter. | |
| | **31A-23b-202. Qualifications for a license.** | |
| | **31A-23b-202. Qualifications for a license.**<br>(1) (a) The commissioner shall issue or renew a license to a person to act as a navigator if the person:<br>(i) satisfies the:<br>(A) application requirements under Section 31A-23b-203;<br>(B) character requirements under Section 31A-23b-204;<br>(C) examination and training requirements under Section 31A-23b-205; and<br>(D) continuing education requirements under Section 31A-23b-206;<br>(ii) certifies that, to the extent applicable, the applicant:<br>(A) is in compliance with the surety bond requirements of Section 31A-23b-207; and<br>(B) will maintain compliance with Section 31A-23b-207 during the period for which the license is issued or renewed; and<br>(iii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23b-401.<br>(b) A license issued under this chapter is valid for [~~two years~~] <u>one year</u>. | **Policy change:** The training required by the U.S. Department for Health & Human Services (HHS) training and certification for navigators is an annual process. The changes is proposed to be consistent with the education and certification requirements of HHS. |
| | **31A-23b-205. Examination and training requirements.** | |
| | (1) The commissioner may require applicants for a license to pass an examination and complete a training program as a requirement for a license.<br>(2) The examination described in Subsection (1) shall reasonably relate to:<br>(a) the duties and functions of a navigator;<br>(b) requirements for navigators as established by federal regulation under PPACA; and<br>(c) other requirements that may be established by the commissioner by administrative rule.<br>(3) The examination may be administered by the commissioner or as otherwise specified by administrative rule.<br>(4) The training required by Subsection (1) shall be approved by the commissioner and shall include:<br>(a) accident and health insurance plans;<br>(b) qualifications for and enrollment in public programs;<br>(c) qualifications for and enrollment in premium subsidies;<br>(d) cultural and linguistic competence;<br>(e) conflict of interest standards;<br>(f) exchange functions; and<br>(g) other requirements that may be adopted by the commissioner by administrative rule.<br><u>(5) The training required by Subsection (1) shall consist of:</u> | **Policy change:** The changes proposed to be consistent with the education and certification requirements of HHS; an require navigators to attend a one hour course on Avenue H. |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | (a) at least 21 hours of training prior to obtaining a license;<br>(b) at least 1 of the 21 credit hours described in Subsection (5)(a) be defined contribution training that includes training on use of the Health Insurance Exchange; and<br>(c) the navigator training and certification program developed by the Centers for Medicare and Medicaid Services.<br>[~~(5)~~](6) This section applies only to applicants who are natural persons. | |
| | **31A-23b-206. Continuing education requirements.** | |
| | (3) (a) Continuing education requirements shall require:<br>(i) that a licensee complete [~~24~~] 12 credit hours of continuing education for every [~~two~~] one-year licensing period;<br>(ii) that [~~3~~] at least 2 of the [~~24~~] 12 credit hours described in Subsection (3)(a)(i) be ethics courses; [~~and~~]<br>(iii) that [~~the licensee complete at least half of the required hours through classroom hours of insurance and exchange related instruction.~~] at least 1 of the 12 credit hours described in Subsection (3)(a)(i) be defined contribution courses that include training on use of the Health Insurance Exchange; and<br>(iv) that a licensee complete the annual navigator training and certification program developed by the Centers for Medicare and Medicaid Services.<br>(b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be obtained through:<br>(i) classroom attendance;<br>(ii) home study;<br>(iii) watching a video recording; or<br>[~~(iv) experience credit; or~~]<br>(v) another method approved by rule.<br>(c) A licensee may obtain continuing education hours at any time during the [~~two~~] one-year license period.<br>(d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule[~~:~~<br>~~(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b); and~~<br>~~(ii)~~] authorize one or more continuing education providers, including a state or national professional producer or consultant associations, to:<br>[~~(A)~~](i) offer a qualified program on a geographically accessible basis; and<br>[~~(B)~~](ii) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner. | **Policy change:** The proposed change is to be consistent with the education and certification requirements of HHS. |
| | **31A-23b-301. Unfair practices – Compensation – Limit of scope of practice .** | |
| | (4) A navigator licensed under this chapter is subject to the unfair marketing practices and inducement provisions of Sections 31A-23a-402 and 31A-23a-402.5. | **Codifying existing practice:** The proposed change clarifies navigators are subject not only to inducement provisions, but also unfair marketing practices. |
| | **31A-26-102. Definitions.** | |
| | (2) "Designated home state" means: | |

| | | |
|---|---|---|
| | (a) the state or territory of the United States or the District of Columbia in which an insurance adjuster:<br>(i) does not maintain the adjuster's principal:<br>(A) place of residence; or<br>(B) place of business; and<br>(ii) ) if the resident state or territory does not license adjusters for the line of authority sought, the adjuster has qualified for the license as if the person were a resident, including any applicable:<br>(A) examination requirements;<br>(B) fingerprint background check requirements; and<br>(C) continuing education requirements.<br>(3)"Home state" means:<br>(a) a state or territory of the United States or the District of Columbia in which an insurance adjuster:<br>(i) maintains the adjuster's principal:<br>(A) place of residence; or<br>(B) place of business; and<br>(ii) is licensed to act as a resident adjuster; or<br>(b) if the resident state or territory does not license adjusters for the line of authority sought, any state in which the adjuster:<br>(i) is licensed;<br>(ii) is in good standing; and<br>(iii) has designated as the adjuster's designated home state.<br>[~~(2)~~](4) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insurers.<br>[~~(3)~~](5) "Insurance adjusting" or "adjusting" means directing or handling the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy. | |
| | **31A-26-207. Examination requirements.** | |
| | (5) The requirements of this section do not apply to:<br>(a) members of the Utah State Bar[~~,~~]; or<br>(b) applicants for the crop insurance license class who have satisfactorily completed the:<br>(i) National Crop Insurance Services Crop Adjuster Proficiency Program; or<br>(ii) loss adjustment training curriculum and competency testing required by the Federal Crop Insurance Corporation Standard Reinsurance Agreement. | |
| | **31A-26-214.5. License lapse and voluntary surrender.** | |
| | (1) (a) A license issued under this chapter shall lapse if the licensee fails to:<br>(i) pay when due a fee under Section 31A-3-103;<br>(ii) complete continuing education requirements under Section 31A-26-206 before submitting the license renewal application;<br>(iii) submit a completed renewal application as required by Section 31A-26-202;<br>(iv) submit additional documentation required to complete the licensing process as related to a specific license type or | |

| | | |
|---|---|---|
| | license classification; or<br>(v) maintain an active license in [~~a resident~~]the licensee's home state if the licensee is a nonresident licensee.<br>(b) (i) A licensee whose license lapses due to the following may request an action described in Subsection (1)(b)(ii):<br>(A) military service;<br>(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or<br>(C) some other extenuating circumstances, such as long-term medical disability.<br>(ii) A licensee described in Subsection (1)(b)(i) may request:<br>(A) reinstatement of the license no later than one year after the day on which the license lapses; and<br>(B) waiver of any of the following imposed for failure to comply with renewal procedures:<br>(I) an examination requirement;<br>(II) reinstatement fees set under Section 31A-3-103;<br>(III) continuing education requirements; or<br>(IV) other sanction imposed for failure to comply with renewal procedures. | |
| | **31A-27a-102. Definitions.** | |
| | (32) As the context requires, "receiver" means the commissioner or his designee, including a rehabilitator, liquidator, or ancillary receiver. | |
| | **31A-27a-201. Receivership court's seizure order.** | |
| | (6) (a) An insurer subject to an ex parte seizure order under this section may petition the receivership court at any time after the issuance of a seizure order for a hearing and review of the basis for the seizure order.<br>(b) The receivership court shall hold the hearing and review requested under this Subsection (6) not more than 15 days after the day on which the request is received or as soon thereafter as the court may allow.<br>(c) A hearing under this Subsection (6):<br>(i) may be held privately in chambers; and<br>(ii) shall be held privately in chambers if the insurer proceeded against requests that it be private.<br>(7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership court that a person whose interest is or will be substantially affected by the seizure order did not appear at the hearing and has not been served, the receivership court may order that notice be given to the person.<br>(b) An order under this Subsection (7) that notice be given may not stay the effect of any seizure order previously issued by the receivership court.<br>(8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of the police department of a municipality in the state to furnish the commissioner with necessary deputies or officers to assist the commissioner in making and enforcing the seizure order.<br>(9) The commissioner may appoint a receiver under this section whose costs and expenses shall be paid by the insurer. | |
| | **31A-29-110. Pool Administrator – Selection -- Powers.** | |
| | (3)[~~(a)~~] The pool administrator shall serve for a period of three years, with ~~two one-year~~ yearly extension options, subject to the terms, conditions, and limitations of the contract between the board and the administrator.[ | **Policy change:** Due to the guaranteed issuance of insurance |

| | | |
|---|---|---|
| | ~~(b) At least one year prior to the expiration of the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator.~~<br>~~(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of the period of service under Subsection (3)(a).~~] | coverage in the ACA for all individuals, HIPUtah terminated coverage for all enrollees. The proposed changes removes sections that are no longer applicable. |
| | **31A-29-111. Eligibility -- Limitations.** | |
| | [~~(1) (a) Except as provided in Subsection (1)(b)~~and (7)~~, an individual who is not HIPAA eligible is eligible for pool coverage if the individual:~~<br>~~(i) pays the established premium;~~<br>~~(ii) is a resident of this state; and~~<br>~~(iii) meets the health underwriting criteria under Subsection (5)(a).~~<br>~~(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:~~<br>~~(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;~~<br>~~(ii) the individual has terminated coverage in the pool, unless:~~<br>~~(A) 12 months have elapsed since the termination date; or~~<br>~~(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;~~<br>~~(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;~~<br>~~(iv) the individual is an inmate of a public institution;~~<br>~~(v) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;~~<br>~~(vi) the individual's health condition does not meet the criteria established under Subsection (5);~~<br>~~(vii) the individual is eligible for coverage under an employer group that offers a health benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members as:~~<br>~~(A) an eligible employee;~~<br>~~(B) a dependent of an eligible employee; or~~<br>~~(C) a member;~~<br>~~(viii) the individual is covered under any other health benefit plan;~~<br>~~(ix) except as provided in Subsections (3) and (6), at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application; or~~<br>~~(x) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.~~<br>~~(2) (a) Except as provided in Subsection (2)(b)~~ and (7)~~, an individual who is HIPAA eligible is eligible for pool coverage if the individual:~~<br>~~(i) pays the established premium; and~~<br>~~(ii) is a resident of this state.~~<br>~~(b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the~~ | **Codifying existing practice:** Due to the guaranteed issuance of insurance coverage in the ACA for all individuals, HIPUtah terminated coverage for all enrollees. The proposed changes removes sections that are no longer applicable. |

| | | |
|---|---|---|
| | ~~following conditions apply:~~<br>~~(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;~~<br>~~(ii) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;~~<br>~~(iii) the individual is covered under any other health benefit plan;~~<br>~~(iv) the individual is eligible for coverage under an employer group that offers a health benefit plan or self-insurance arrangements to its eligible employees, dependents, or members as:~~<br>~~(A) an eligible employee;~~<br>~~(B) a dependent of an eligible employee; or~~<br>~~(C) a member;~~<br>~~(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;~~<br>~~(vi) the individual is an inmate of a public institution; or~~<br>~~(vii) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.~~<br>~~(3) (a) Notwithstanding Subsection (1)(b)(ix)~~ and (7), ~~if otherwise eligible under Subsection (1)(a), an individual whose health care insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).~~<br>~~(b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.~~<br>~~(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.~~<br>~~(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:~~<br>~~(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and~~<br>~~(ii) if the other state's benefit limitation was not reached.~~<br>~~(4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.~~<br>~~(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.~~<br>~~(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:~~<br>~~(i) health condition; and~~<br>~~(ii) expected claims so that the expected claims are anticipated to remain within available funding.~~<br>~~(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).~~<br>~~(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).~~<br>~~(6) (a) Notwithstanding Subsection (1)(b)(ix)~~ and (7), ~~if otherwise eligible under Subsection (1)(a), an individual whose individual health care insurance coverage was involuntarily terminated, is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii) and (x).~~ | |

| | | |
|---|---|---|
| | ~~(b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the termination date of the previous individual health care insurance coverage.~~<br>~~(c) The effective date of this state's pool coverage shall be the date of termination of the previous individual coverage.~~<br>~~(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived to the extent to which the waiting period was satisfied under the individual health insurance plan.~~]<br>Notwithstanding a rule promulgated by the board pursuant to 31A-29-106(1)(n) that establishes eligibility for the pool, no person is eligible for pool coverage on or after January 1, 2014. | |
| | **31A-29-113. Benefits – Additional types of pool insurance – Preexisting conditions – Waiver – Maximum benefits.** | |
| | (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:<br>(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and<br>(ii) are not otherwise limited or excluded.<br>(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.<br>(c) Sections 31A-21-312 and 31A-21-313 apply to coverage issued under this chapter. | **Policy change:** Adopts current law that applies to all insurers for submission of proof of loss and limitation of actions to be applied to HIPUtah enrollees. |
| | **31A-29-115. Cancellation -- Notice.** | |
| | (1) [~~(a)~~ ]On the date of renewal, the pool may cancel an enrollee's policy if[~~:~~<br>~~(i) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(5); and~~<br>~~(ii)~~] the pool has provided written notice to the enrollee's last-known address no less than 60 days before cancellation[~~; and~~<br>~~(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.~~<br>~~(b) The pool shall issue a certificate of insurability to an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the requirements of Subsection 31A-29-111(5) are met~~].<br>(2) The pool may cancel an enrollee's policy at any time if:<br>(a) the pool has provided written notice to the enrollee's last-known address no less than 15 days before cancellation; and<br>(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;<br>(ii) there is nonpayment of premiums; or<br>(iii) the pool determines that the enrollee [~~does~~]did not meet the eligibility requirements[~~ set forth in Section 31A-29-111~~]at the time of application or at any time during coverage, in which case:<br>(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;<br>(B) retroactive termination may not exceed three years; and<br>(C) the board's remedy under this Subsection (2)(b) shall be a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with Subsection 31A-29-119(3).<br>(3) The pool shall cancel all enrollee's policies when an individual insurer is required to accept all individuals who apply for coverage without regard to health status as required by PPACA Sec. 2702. | **Codifying existing practice:** Due to the guaranteed issuance of insurance coverage in the ACA for all individuals, HIPUtah terminated coverage for all enrollees. The proposed changes removes sections that are no longer applicable. |
| | **31A-29-117. Premium rates.** | |
| | (1) (a) Premium charges for coverage under the pool may not be unreasonable in relation to: | **Codifying existing practice:** |

| | | |
|---|---|---|
| | (i) the benefits provided;<br>(ii) the risk experience; and<br>(iii) the reasonable expenses provided in the coverage.<br>(b) Separate schedules of premium rates based on age and other appropriate demographic characteristics may apply for individual risks.<br>(2) [~~Small employer carriers, as defined in Section 31A-30-103, shall annually inform the commissioner by February 1 of the carrier's:~~<br>~~(a) small employer index premium rates as of January 1 of the current and preceding year; and~~<br>~~(b) average percentage change in the index premium rate as of January 1, of the current and preceding year.~~<br>~~(3) (a)~~ Premium rates may be adjusted by the board on a biannual basis, for an effective date of January 1 and July 1.<br>~~(b) In adjusting premium rates, the board shall:~~<br>~~(i) consider the average increase in small employer index rates for the five largest small employer carriers submitted under Subsection (2); and~~<br>~~(ii) be subject to Subsection (1).~~<br>~~(4)~~](3) The board may establish a premium scale based on income. The highest rate may not exceed the expected claims and expenses for the individual.<br>[~~(5) If an individual is HIPAA eligible, the maximum premium rate for that individual may not exceed the amount permitted under HIPAA.~~<br>~~(6)~~](4) All rates and rate schedules shall be submitted by the board to the commissioner for approval. | Due to the guaranteed issuance of insurance coverage in the ACA for all individuals, HIPUtah terminated coverage for all enrollees. The proposed changes removes sections that are no longer applicable. |
| | **31A-30-102. Purpose statement.** | |
| | The purpose of this chapter is to:<br>(1) prevent abusive rating practices;<br>(2) require disclosure of rating practices to purchasers;<br>(3) establish rules regarding:<br>(a) a universal individual and small group application; and<br>(b) renewability of coverage;<br>(4) improve the overall fairness and efficiency of the individual and small group insurance market;<br>(5) provide increased access for individuals and small employers to health insurance; and<br>(6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the ~~Internet portal~~ Health Insurance Exchange created by Section 63M-1-2504. | **Technical change:** Changes term Internet portal to Health Insurance Exchange to be consistent with 63M-1-2504. |
| | **31A-30-103. Definitions.** | |
| | As used in this chapter:<br>(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with [~~Sections 31A-30-106 and 31A-30-106.1~~]the provisions of Title 31A, Chapter 30, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans. | **Codifying existing practice:** For policies issued on or after January 1, 2014, the ACA prohibits certain rating practices. Insurers may no longer rate based on health status or gender. |

| | | |
|---|---|---|
| | (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.<br>(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.<br>(4) (a) "Bona fide employer association" means an association of employers:<br>(i) that meets the requirements of Subsection 31A-22-701(2)(b);<br>(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;<br>(iii) that is organized:<br>(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and<br>(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and<br>(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.<br>(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):<br>(i) how association members are solicited;<br>(ii) who participates in the association;<br>(iii) the process by which the association was formed;<br>(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;<br>(v) the powers, rights and privileges of employer members; and<br>(vi) who actually controls and directs the activities and operations of the benefit programs.<br>(5) "Carrier" means any person or entity that provides health insurance in this state including:<br>(a) an insurance company;<br>(b) a prepaid hospital or medical care plan;<br>(c) a health maintenance organization;<br>(d) a multiple employer welfare arrangement; and<br>(e) any other person or entity providing a health insurance plan under this title.<br>(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.<br>(b) "Case characteristics" do not include:<br>(i) duration of coverage since the policy was issued;<br>(ii) claim experience; and<br>(iii) health status.<br>(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.<br>(8) [~~"Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.~~ | Additionally, the ACA limits how an insurer may rate for geographic area, family status and age.<br><br>**Technical change:** Removes |

| | | |
|---|---|---|
| | ~~(9) ~~]"Covered carrier" means any individual carrier or small employer carrier subject to this chapter.<br>[~~(10)~~](9) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.<br>[~~(11)~~](10) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.<br>[~~(12)~~](11) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:<br>(a) the health benefit plan covering the covered individual; and<br>(b) Chapter 22, Part 6, Accident and Health Insurance.<br>[~~(13)~~](12) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.<br>[~~(14)~~](13) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.<br>[~~(15)~~](14) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:<br>(a) coverage is offered through:<br>(i) an association;<br>(ii) a trust;<br>(iii) a discretionary group; or<br>(iv) other similar groups; or<br>(b) the policy or contract is situated out-of-state.<br>(16) "Individual conversion policy" means a conversion policy issued to:<br>(a) an individual; or<br>(b) an individual with a family.<br>~~[ (17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.~~<br>~~(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.~~<br>~~(19)~~](15) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.<br>[~~(20)~~](16) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.<br>[~~(21)~~](17) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.<br>(b) A covered carrier may not have:<br>(i) more than one rating period in any calendar month; and<br>(ii) no more than 12 rating periods in any calendar year.[<br>~~(22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.~~<br>(~~23~~)](18) "Short-term limited duration insurance" means a health benefit product that:<br>(a) is not renewable; and | references to conversion policies which are no longer a requirement effective January 1, 2014.<br><br>**Policy change:** Removes the provisions related to enrollment caps in the individual market due to guarantee issuance requirements in the ACA effective January 1, 2014.<br><br>**Codifying existing practice:** Effective January 1, 2014, the ACA prohibits insurers to require |

| | | |
|---|---|---|
| | (b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.<br>[~~(24)~~](19) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:<br>(a) coverage is offered through:<br>(i) an association;<br>(ii) a trust;<br>(iii) a discretionary group; or<br>(iv) other similar grouping; or<br>(b) the policy or contract is situated out-of-state.[<br>~~(25) "Uninsurable" means an individual who:~~<br>~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or~~<br>~~(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and~~<br>~~(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g) and (h) for which coverage the applicant is applying.~~<br>~~(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:~~<br>~~(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and~~<br>~~(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.]~~ | a person to be a resident for at least 12 months in order to obtain coverage.<br><br>**Policy change:** Removes the provisions related to enrollment caps in the individual market due to guarantee issuance requirements in the ACA effective January 1, 2014. |
| | **31A-30-107.5. Preexisting condition exclusion – Condition-specific exclusion riders – Limitation periods.** | |
| | (1) [~~A~~ ]For policies issued or renewed prior to January 1, 2014, a health benefit plan may impose a preexisting condition exclusion only if the provision complies with Subsection 31A-22-605.1(4).<br>(2) For policies issued or renewed prior to January 1, 2014:<br>(a) In accordance with Subsection (2)(b), an individual carrier:<br>(i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to:<br>(A) a specific physical condition;<br>(B) a specific disease or disorder; and<br>(C) any specific or class of prescription drugs; and<br>(ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including drugs, when utilized for the treatment and care of the conditions, diseases, or disorders listed in Subsection (2)(b).<br>(b) (i) Except as provided in Section 31A-22-630 and Subsection (2)(b)(ii), the following may be the subject of a condition-specific exclusion rider:<br>(A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow, fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;<br>(B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius, interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, | **Codifying existing practice:** The Affordable Care Act (ACA) prohibits preexisting condition limitations on major medical plans offered on or after January 1, 2014. |

| | | |
|---|---|---|
| | spermatocele, endometriosis;<br>(C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies, deviated nasal septum, and sinus related conditions, diseases, and disorders;<br>(D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases, and disorders;<br>(E) goiter and other thyroid related conditions, diseases, or disorders;<br>(F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus and other eye related conditions, diseases, and disorders;<br>(G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions, diseases, and disorders;<br>(H) Baker's cyst, ganglion cyst;<br>(I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC Doulourex, varicose veins, vestibular disorders;<br>(J) sleep disorders and speech disorders; and<br>(K) any specific or class of prescription drugs.<br>(ii) Subsection (2)(b)(i) does not apply:<br>(A) for the treatment of asthma; or<br>(B) when the condition is due to cancer.<br>(iii) A condition-specific exclusion rider:<br>(A) shall be limited to the excluded condition, disease, or disorder and any complications from that condition, disease, or disorder;<br>(B) may not extend to any secondary medical condition; and<br>(C) shall include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition, disease, or disorder."<br>(c) If an individual carrier issues a condition-specific exclusion rider, the condition-specific exclusion rider shall remain in effect for the duration of the policy at the individual carrier's option.<br>(d) An individual policy issued in accordance with this Subsection (2) is not subject to Subsection 31A-26-301.6(7).<br>(3) [~~Notwithstanding~~ ]For policies issued or renewed prior to January 1, 2014 and notwithstanding the other provisions of this section, a health benefit plan may impose a limitation period if:<br>(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition, disease, or disorder that is excluded from coverage during the limitation period;<br>(b) the limitation period does not exceed 12 months;<br>(c) the limitation period is applied uniformly; and<br>(d) the limitation period is reduced in compliance with Subsections 31A-22-605.1(4)(a) and (4)(b). | |
| | **31A-30-108. Eligibility of small employer and individual market.** | |
| | (1) (a) Small employer carriers shall accept [~~residents~~] every small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec. 2702.<br>(b) Individual carriers shall accept [~~residents~~] every individual that applies for individual coverage [~~pursuant to:~~ | **Codifying existing practice:** Effective January 1, 2014, the ACA requires small employer |

| | | |
|---|---|---|
| | ~~(i) Health Insurance Portability and Accountability Act, Sec. 2741(a) (b); and~~<br>~~(ii) Subsection (3)~~]as set forth in PPACA, Sec. 2702.<br>(2) (a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.<br>(b) Small employer carriers may:<br>(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and<br>(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).<br>[~~(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:~~<br>~~(a) the individual is not covered or eligible for coverage:~~<br>~~(i) (A) as an employee of an employer;~~<br>~~(B) as a member of an association; or~~<br>~~(C) as a member of any other group; and~~<br>~~(ii) under:~~<br>~~(A) a health benefit plan; or~~<br>~~(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;~~<br>~~(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:~~<br>~~(i) the Medicare program established under Title XVIII of the Social Security Act;~~<br>~~(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or~~<br>~~(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;~~<br>~~(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:~~<br>~~(i) Medicare supplement policy;~~<br>~~(ii) conversion option;~~<br>~~(iii) continuation or extension under COBRA; or~~<br>~~(iv) state extension;~~<br>~~(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and~~<br>~~(e) the individual is certified as ineligible for the Health Insurance Pool if:~~<br>~~(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or~~<br>~~(ii) the individual applies for coverage with any individual carrier within 45 days after:~~<br>~~(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or~~ | and individual insurers to accept all persons applying for coverage. The proposed changes remove Utah's prior HIPAA alternative mechanism which is no longer applicable. |

| | | |
|---|---|---|
| | ~~(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.~~<br>~~(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.~~<br>~~(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:~~<br>~~(i) cancellation of coverage under Subsection 31A-29-115(1); or~~<br>~~(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.~~<br>~~(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.~~<br>~~(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.~~<br>~~(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:~~<br>~~(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and~~<br>~~(ii) the commissioner finds that the carrier's issuance of new individual policies:~~<br>~~(A) is in the best interests of the state; and~~<br>~~(B) does not provide an unfair advantage to the carrier.~~<br>~~(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in Health Insurance Portability and Accountability Act, Sec. 2741 (a) (b).~~<br>~~(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the department.~~<br>~~(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:~~<br>~~(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and~~<br>~~(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:~~<br>~~(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and~~<br>~~(B) applies this section uniformly to all employers without regard to:~~<br>~~(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or~~<br>~~(II) any health status-related factor relating to an employee or dependent of an employee.~~<br>~~(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.~~ | |

| | | |
|---|---|---|
| | ~~(ii) This Subsection (7)(b) does not:~~<br>~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~<br>~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.~~<br>~~(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.~~] | |
| | **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.** | |
| | (1) A producer may be listed on the Health Insurance Exchange as a credentialed producer[~~- for the defined contribution arrangement market in accordance with Section 63M-1-2504~~], if the producer is designated as [~~an appointed -~~]credentialed agent for the [~~defined contribution arrangement market -~~]Health Insurance Exchange in accordance with Subsection (2).<br>(2) A producer whose license under this title authorizes the producer to sell [~~defined contribution arrangement health benefit plans -~~]accident and health insurance may be [~~appointed to the defined contribution arrangement market -~~]credentialed by [~~on -~~]the Health Insurance Exchange [~~by the Insurance Department -~~]and may sell any product on the Health Insurance Exchange, if the producer:<br>(a) [~~submits an application to the Insurance Department to be appointed as a producer for the defined contribution arrangement market on the Health Insurance Exchange;~~<br>~~(b) -~~]is an appointed agent [~~in accordance with Subsection (3), for products offered [in the defined contribution arrangement market of the Health Insurance Exchange, -~~]with [~~the~~]all carriers that offer [~~a defined contribution arrangement health benefit plan ~~]plans on the Health Insurance Exchange; and<br>[~~(c)~~](b) completes each year the Health Insurance Exchange training that includes training on premium assistance programs.[~~- completed continuing education for the defined contribution arrangement market that:~~<br>~~(i) is required by administrative rule adopted by the commissioner; and~~<br>~~(ii) provides training on premium assistance programs.~~]<br>(3) A carrier shall appoint a producer to sell the carrier's products [~~in the defined contribution arrangement market of -~~]on the Health Insurance Exchange, within 30 days of the notice required in Subsection (3)(b), if:<br>(a) the producer is currently appointed by a majority of the carriers in the Health Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange; and<br>(b) the producer informs the carrier that the producer is:<br>(i) applying to be appointed to [~~the defined contribution arrangement market in -~~]sell the carrier's products on the Health Insurance Exchange;<br>(ii) appointed by a majority of the carriers [~~in the defined contribution arrangement market in -~~]on the Health Insurance Exchange;<br>(iii) willing to complete training regarding the carrier's products offered on [~~the defined contribution arrangement market in ~~]the Health Insurance Exchange; and<br>(iv) willing to sign the contracts and business associate's agreements that the carrier requires for appointed producers in the Health Insurance Exchange. | **Policy change:** Changes the requirement for a producer to be "appointed" by the insurance department to sell on the Health Insurance Exchange, to be "credentialed" by the exchange.<br><br>Requires producers to attend Health Insurance Exchange training on an annual basis in order for the Health Insurance Exchange to consider credentialing a producer. |
| | **31A-30-211. Insurer disclosure.** | |
| | (1) [~~The Health Insurance Exchange shall provide an employer's producer with the group's risk factor used to calculate the~~ | **Codifying existing practice:** |

| | | |
|---|---|---|
| | ~~employer group's premium at the time of:~~<br>~~(a) the initial offering of a health benefit plan; and~~<br>~~(b) the renewal of a health benefit plan.~~<br>~~(2) For health benefit plans that renew on or after March 1, 2012:~~]<br>(a)[~~a~~]A carrier shall provide an employer and the employer's producer with premium renewal rates at least 60 days prior to the group's renewal date for a plan offered under Part 1, Individual and Small Employer Group; and<br>(b) the Health Insurance Exchange shall provide an employer and the employer's producer with premium renewal rates at least 60 days prior to the group's renewal date for a plan offered under Part 2, Defined Contribution Arrangements.<br>[~~(3)~~](2) An insurer does not have to provide additional notice of premium renewal rates to the employer or the employer's producer if the Health Insurance Exchange provides notice in accordance with Subsection (2)(b). | Effective January 1, 2014, insurers are no longer allowed to rate based on health risk factors. Therefore a group risk factor is no longer used to calculate premiums. |
| | **31A-37-501. Reports to commissioner.** | |
| | (1) A captive insurance company is not required to make a report except those provided in this chapter.<br>(2) (a) Before March 1 of each year, a captive insurance company shall submit to the commissioner a report of the financial condition of the captive insurance company, verified by oath of two of the executive officers of the captive insurance company.<br>(b) Except as provided in Sections 31A-37-204 and 31A-37-205, a captive insurance company shall report:<br>(i) using generally accepted accounting principles, except to the extent that the commissioner requires, approves, or accepts the use of a statutory accounting principle;<br>(ii) using a useful or necessary modification or adaptation to an accounting principle that is required, approved, or accepted by the commissioner for the type of insurance and kind of insurer to be reported upon; and<br>(iii) supplemental or additional information required by the commissioner.<br>(c) Except as otherwise provided:<br>(i) [~~an association captive insurance company and an industrial insured group~~] all captive insurance companies shall file the report required by Section 31A-4-113; and<br>(ii) an industrial insured group shall comply with Section 31A-4-113.5.<br>(3) (a) A pure captive insurance company may make written application to file the required report on a fiscal year end that is consistent with the fiscal year of the parent company of the pure captive insurance company.<br>(b) If the commissioner grants an alternative reporting date for a pure captive insurance company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal year end.<br>(4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall file with the commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two of the alien captive insurance company's executive officers.<br>(b) If the commissioner is satisfied that the annual report filed by the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the annual statement required for a captive insurance company under this section with respect to business written in the alien jurisdiction.<br>(c) A waiver by the commissioner under Subsection (4)(b):<br>(i) shall be in writing; and | |

| | | |
|---|---|---|
| | (ii) is subject to public inspection. | |
| | **31A-40-203. Covered employee.** | |
| | (1) (a) An individual is a covered employee of a professional employer organization if the individual is coemployed pursuant to a professional employer agreement subject to this chapter.<br>(b) An individual who is a covered employee under a professional employer agreement is a covered [~~employer~~] employee, whether or not the professional employer organization provides the notice required by Subsection 31A-40-202(3), the earlier of the day on which:<br>(i) the employee is first compensated by the professional employer organization; or<br>(ii) the client notifies the professional employer organization of a new hire.<br>(2) An individual who is an officer, director, shareholder, partner, or manager of a client is a covered employee:<br>(a) to the extent that the client and the professional employer organization expressly agree in the professional employer agreement that the individual is a covered employee;<br>(b) if the conditions of Subsection (1) are met; and<br>(c) if the individual acts as an operational manager or performs day-to-day an operational service for the client. | |
| | **31A-40-209. Workers' compensation.** | |
| | (1) In accordance with Section 34A-2-103, a client is responsible for securing workers' compensation coverage for a covered employee.<br>(2) Subject to the requirements of Section 34A-2-103, if a professional employer organization obtains or assists a client in obtaining workers' compensation insurance pursuant to a professional employer agreement:<br>(a) the professional employer organization shall ensure that the client maintains and provides workers' compensation coverage for a covered employee in accordance with Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;<br>(b) the workers' compensation coverage may show the professional employer organization as the named insured through a [~~multiple coordinated~~] master policy, if:<br>(i) the client is shown as an insured by means of an endorsement for each individual client;<br>(ii) the experience modification of a client is used; and<br>(iii) the insurer files the endorsement with the Division of Industrial Accidents as directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;<br>(c) at the termination of the professional employer agreement, if requested by the client, the insurer shall provide the client records regarding the loss experience related to workers' compensation insurance provided to a covered employee pursuant to the professional employer agreement; and<br>(d) the insurer shall notify a client if the workers' compensation coverage for the client is terminated.<br>(3) In accordance with Section 34A-2-105, the exclusive remedy provisions of Section 34A-2-105 apply to both the client and the professional employer organization under a professional employer agreement regulated under this chapter.<br>(4) Notwithstanding the other provisions in this section, an insurer may choose whether to issue:<br>(a) a policy for a client; or<br>(b) a [~~multiple coordinated~~] master policy with the client shown as an additional insured by means of an individual | |

| | | |
|---|---|---|
| | endorsement. | |
| | **31A-42-202. Contents of plan.** | |
| | (1) The board shall submit a plan of operation for the risk adjuster to the commissioner. The plan shall:<br>(a) establish the methodology for implementing:<br>(i) Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements; and<br>(ii) the participation of small employer group defined contribution arrangement health benefit plans;<br>(b) establish regular times and places for meetings of the board;<br>(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;<br>(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and<br>(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.<br>(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:<br>(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and<br>(ii) underwriting mechanisms and employer eligibility guidelines:<br>(A) consistent with the federal Health Insurance Portability and Accountability Act; and<br>(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.<br>(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual <u>in the defined contribution arrangement market</u> are determined, including:<br>(i) the identification of an initial rate for a qualified individual based on:<br>(A) standardized age bands submitted by participating insurers; and<br>(B) wellness incentives for the individual as permitted by federal law; and<br>(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.1.<br>(c) The plan adopted under Subsection (2)(a) <u>for the defined contribution arrangement market</u> shall outline how:<br>(i) premium contributions for qualified individuals shall be submitted to the Health Insurance Exchange in the amount determined under Subsection (2)(b); and<br>(ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's rating factor determined in accordance with the plan.<br>(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between <u>defined contribution arrangement market</u> insurers that:<br>(i) identifies health care conditions subject to risk adjustment;<br>(ii) establishes an adjustment amount for each identified health care condition;<br>(iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and<br>(iv) computes all risk adjustments. | **Codifying existing practice:** Clarifies the Risk Adjuster Board applies only to defined contribution arrangements. |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | (e) The board may amend the plan if necessary to:<br>(i) maintain the proper functioning and solvency of the defined contribution arrangement market and the risk adjuster mechanism;<br>(ii) mitigate significant issues of risk selection; or<br>(iii) improve the administration of the risk adjuster mechanism.<br>(3) The board shall establish a mechanism in which the defined contribution arrangement market participating carriers shall submit their plan base rates, rating factors, and premiums to the commissioner for an actuarial review under the provisions of Section 31A-30-115 prior to the publication of the premium rates on the Health Insurance Exchange. | |
| | **31A-43-102. Definitions.** | |
| | For purposes of this chapter:<br>(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer is in compliance with the provisions of this chapter, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the stop-loss insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop-loss insurance coverage.<br>(2) "Aggregate attachment point" means the dollar amount [~~in losses for eligible expenses~~ ]of covered claims incurred by a small employer plan beyond which the stop-loss insurer incurs liability for [~~all or part of the~~ ]losses incurred by the small employer plan, subject to limitations included in the contract.<br>(3) "Coverage" means the combination of the employer plan design and the stop-loss contract design.<br>(4) "Expected claims" means the amount of claims that, in the absence of [~~a~~]aggregate stop-loss [~~contract~~]insurance, are projected to be incurred by a small employer health plan using reasonable and accepted actuarial principles.<br>(5) "Lasering":<br>(a) means increasing or removing stop-loss coverage for a specific individual within an employer group; and<br>(b) includes other practices that are prohibited by the commissioner by administrative rule that result in lowering the stop-loss premium for the employer by transferring the risk for an [~~individual~~ ]individual's claims back to the employer.<br>(6) "Small employer" means an employer who, with respect to a calendar year and to a plan year:<br>(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and<br>(b) employs at least two employees on the first day of the plan year.<br>(7) "Specific attachment point" means the dollar amount [~~in losses for eligible expenses~~ ]of covered claims attributable to a single individual covered by a small employer plan in a contract year beyond which the stop-loss insurer assumes [~~all or part of~~ ]the liability for losses incurred by the small employer plan, subject to limitations included in the contract.<br>(8) "Stop-loss insurance" means insurance purchased by a small employer for which the stop-loss insurer assumes[~~, on a per loss basis,~~] all loss amounts of the small employer's plan in excess of a stated amount, subject to the policy limit. | **Technical change:** Clarifies terms for covered claims rather than eligible expenses; and removes confusion to reference "losses" rather changes "all or part of the losses."<br><br>**Technical change:** Clarifies lasering is transferring the risk of the individual's claims back to the employer, rather than transferring the risk for an individual. |
| | **31A-43-301. Stop-loss insurance coverage standards.** | |
| | (1) A small employer stop-loss insurance contract shall:<br>(a) be issued to the small employer to provide insurance to the group health benefit plan, not the employees of the small | **Clarifies existing policy:** Requires stop-loss insurer to |

| | | |
|---|---|---|
| | employer;<br>(b) use a standard application form developed by the commissioner by administrative rule;<br>(c) have a contract term with guaranteed rates for at least 12 months, without adjustment, unless there is a change in the benefits provided under the small employer's health plan during the contract period;<br>(d) include both a specific attachment point and an aggregate attachment point in a contract;<br>(e) align stop-loss plan benefit limitations and exclusions with a small employer's health plan benefit limitations and exclusions, including any annual or lifetime limits in the employer's health plan;<br>(f) have an annual specific attachment point that is at least $10,000;<br>(g) have an annual aggregate attachment point that may not be less than 90% of expected claims;<br>(h) pay stop-loss claims:<br>(i) incurred during the contract period; and<br>(ii) [~~submitted~~] paid within 12 months after the expiration date of the contract; and<br>(i) include provisions to cover incurred and unpaid claims if a small employer plan terminates.<br>(2) A small employer stop-loss contract shall not:<br>(a) include lasering; and<br>(b) pay claims directly to an individual employee, member, or participant. | consider claims paid within 12 months after the expiration of the stop-loss contract, rather than claims submitted. |
| | **31A-43-302. Stop-loss restrictions – Filing requirements.** | |
| | (1) [~~A stop-loss insurer shall demonstrate to the commissioner that the rates associated with specific and aggregate attachment points retained by a small employer group under the insurer's stop-loss plan are actuarially sound.~~<br>~~(2)~~ ]A stop-loss insurer shall file the stop-loss insurance contract form and [~~rates~~] rating methodology with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss insurance contract may be issued or delivered in the state.<br>[~~(3)~~](2) A stop-loss insurer shall file with the commissioner, annually on or before April 1, in a form and manner required by the commissioner by administrative rule adopted by the commissioner:<br>(a) an actuarial memorandum and certification which demonstrates that the insurer is in compliance with this chapter;[~~-and~~]<br>(b) the stop-loss insurer's stop-loss experience<br>[~~(4)~~](3) Each insurer shall maintain at its principal place of business:<br>(a) a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate the rating methods and practices are:<br>(i) based upon commonly accepted actuarial assumptions; and<br>(ii) in accordance with sound actuarial principles; and<br>(b) a copy of the [~~actuarial certification -~~]annual filing required by Subsection [~~(3)~~](2). | **Clarifying existing policy:** Requires stop-loss insurers to file rating methodology with each filing, and demonstrate compliance on an annual basis. |
| | **31A-43-303. Stop-loss insurance disclosure.** | |
| | A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commissioner through administrative rule, which shall include at least the following information:<br>(1) the complete costs for the stop-loss contract;<br>(2) the date on which the insurance takes effect and terminates, including renewability provisions; | **Technical change:** Corrects numbering. |

| | | |
|---|---|---|
| | (3) the aggregate attachment point and the specific attachment point;<br>(4) any limitations on coverage;<br>(5) an explanation of monthly accommodation and disclosure about any monthly accommodation features included in the stop-loss contract; and<br>(6) a description of terminal liability funding, including[~~:~~<br>~~(a)~~] the cost of processing claims before and after the termination of the contract; and<br>[~~(b)~~](7) maximum claims liability to the employer. | |
| | **31A-43-304. Administrative rules.** | |
| | The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:<br>(1) implement this chapter;<br>(2) [~~assure that differences in rates charged are reasonable[ and reflect objective differences in plan design];~~<br>~~(3)~~] define lasering practices that are prohibited by this chapter;<br>[~~(4)~~](3) establish the form and manner of the actuarial certification and the annual report on stop-loss experience required by Section 31A-43-302;<br>[~~(5)~~](4) establish the form and manner of the disclosure required by Section 31A-43-303;<br>[~~(6)~~](5) assure the rates associated with the specific attachment points and aggregate attachment points are actuarially sound and are not against the public interest; and<br>[~~(7)~~](6) assure that stop-loss contracts include provisions to cover incurred and unpaid claims if a small employer plan terminates. | **Technical change:** Removes unnecessary rule making requirements. |
| | **53-13-103. Law enforcement officer.** | |
| | (1) (a) "Law enforcement officer" means a sworn and certified peace officer who is an employee of a law enforcement agency that is part of or administered by the state or any of its political subdivisions, and whose primary and principal duties consist of the prevention and detection of crime and the enforcement of criminal statutes or ordinances of this state or any of its political subdivisions.<br>(b) "Law enforcement officer" specifically includes the following:<br>(i) any sheriff or deputy sheriff, chief of police, police officer, or marshal of any county, city, or town;<br>(ii) the commissioner of public safety and any member of the Department of Public Safety certified as a peace officer;<br>(iii) all persons specified in Sections 23-20-1.5 and 79-4-501;<br>(iv) any police officer employed by any college or university;<br>(v) investigators for the Motor Vehicle Enforcement Division;<br>(vi) investigators for the Department of Insurance, Fraud Division;<br>(vii) special agents or investigators employed by the attorney general, district attorneys, and county attorneys;<br>(viii) employees of the Department of Natural Resources designated as peace officers by law;<br>([~~viii~~]ix) school district police officers as designated by the board of education for the school district;<br>([~~i~~]x) the executive director of the Department of Corrections and any correctional enforcement or investigative officer designated by the executive director and approved by the commissioner of public safety and certified by the division; | |

# Summary of H.B. xx, Insurance Amendments (10/10/13)
# Representative Jim Dunnigan – Chief Sponsor
# Senate Sponsor –

| | | |
|---|---|---|
| | (xi) correctional enforcement, investigative, or adult probation and parole officers employed by the Department of Corrections serving on or before July 1, 1993;<br>(xii) members of a law enforcement agency established by a private college or university provided that the college or university has been certified by the commissioner of public safety according to rules of the Department of Public Safety;<br>(xiii) airport police officers of any airport owned or operated by the state or any of its political subdivisions; and<br>(x[~~ii~~]iv) transit police officers designated under Section 17B-2a-823. | |
| | **Repealer.** | |
| | 31A-29-112. Medicaid recipients. | |
| | 31A-30-110. Individual enrollment cap. | |
| | 31A-30-111. Limitations on high risk enrollees. | |
| | | |
| | | |