

HEALTH SYSTEM REFORM AMENDMENTS

2012 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill amends provisions in the Health Code and Insurance Code related to the state's strategic plan for health system reform.

Highlighted Provisions:

This bill:

- ▶ clarifies the role of the All Payer Claims Database and the Utah Health Exchange related to prospective and retrospective risk adjusting;
- ▶ makes technical amendments to the Health Department's reports that compare quality measures;
- ▶ amends provisions related to simplified Medicaid enrollment;
- ▶ authorizes an actuarial analysis of providing coverage options to individuals from 133% to 200% of the federal poverty level through a basic health plan beginning in 2014;
- ▶ amends provisions related to the benchmark plan for the dental program in the Children's Health Insurance Program;
- ▶ allows an insurer to provide a premium discount to an employer group based on participation in a wellness program;
- ▶ establishes the Legislature as the entity to determine the benchmark for an essential health benefit plan for the state;
- ▶ clarifies the fees that may be charged for the use of the call center for the Utah



- 28 Health Exchange;
- 29 ▶ re-authorizes the Health System Reform Task Force;
- 30 ▶ repeals provisions that require the state to implement multipayer demonstration
- 31 projects; and
- 32 ▶ makes technical amendments.

33 Money Appropriated in this Bill:

- 34 This bill appropriates in fiscal year 2011-12:
- 35 ▶ To the Senate, as a one-time appropriation:
- 36 • from the General Fund \$15,000 to pay for the Health System Reform Task
- 37 Force; and
- 38 ▶ To the House of Representatives, as a one-time appropriation:
- 39 • from the General Fund \$25,000 to pay for the Health System Reform Task
- 40 Force.

41 Other Special Clauses:

42 This bill provides a repeal date.

43 Utah Code Sections Affected:

44 AMENDS:

- 45 **26-18-2.5**, as enacted by Laws of Utah 2011, Chapter 344
- 46 **26-33a-106.1**, as last amended by Laws of Utah 2010, Chapter 68
- 47 **26-33a-106.5**, as last amended by Laws of Utah 2011, Chapters 297 and 400
- 48 **26-40-106**, as last amended by Laws of Utah 2011, Chapter 400
- 49 **31A-30-106.1**, as last amended by Laws of Utah 2011, Second Special Session, Chapter
- 50 5
- 51 **31A-22-613.5**, as last amended by Laws of Utah 2011, Chapters 297 and 400
- 52 **63I-2-231**, as last amended by Laws of Utah 2011, Chapter 284
- 53 **63M-1-2504**, as last amended by Laws of Utah 2011, Chapter 400

54 ENACTS:

- 55 **26-18-3.8**, Utah Code Annotated 1953
- 56 **31A-30-116**, Utah Code Annotated 1953

57 REPEALS:

- 58 **26-1-39**, as enacted by Laws of Utah 2011, Chapter 400

59 31A-22-614.6, as last amended by Laws of Utah 2011, Chapter 400

60 **Uncodified Material Affected:**

61 ENACTS UNCODIFIED MATERIAL



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

64 Section 1. Section 26-18-2.5 is amended to read:

65 **26-18-2.5. Simplified enrollment and renewal process for Medicaid and other**
66 **state medical programs -- Financial institutions.**

67 (1) The department ~~shall~~ may:

68 (a) apply for grants and accept donations to:

69 (i) make technology system improvements necessary to implement a simplified
70 enrollment and renewal process for the Medicaid program, Utah Premium Partnership, and
71 Primary Care Network Demonstration Project programs; and

72 (ii) conduct an actuarial analysis of the implementation of a basic health care plan in
73 the state in 2014 to provide coverage options to individuals from 133% to 200% of the federal
74 poverty level; and

75 (b) if funding is available~~[-]~~:

76 (i) implement the simplified enrollment and renewal process in accordance with this
77 section~~[-]~~; and

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

79 (2) The simplified enrollment and renewal process established in this section shall, in
80 accordance with Section 59-1-403, provide an eligibility worker a process in which the
81 eligibility worker:

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

83 (b) gets consent to obtain the applicant's adjusted gross income from the State Tax
84 Commission from:

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

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

87 (c) obtains from the State Tax Commission, the adjusted gross income of the applicant
88 or enrollee.

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

90 business in the state to develop and operate a data match system to identify an applicant's or
91 enrollee's assets that:

- 92 (i) uses automated data exchanges to the maximum extent feasible; and
- 93 (ii) requires a financial institution each month to provide the name, record address,
94 Social Security number, other taxpayer identification number, or other identifying information
95 for each applicant or enrollee who maintains an account at the financial institution.

96 (b) The department may pay a reasonable fee to a financial institution for compliance
97 with this Subsection (3), as provided in Section 7-1-1006.

98 (c) A financial institution may not be liable under any federal or state law to any person
99 for any disclosure of information or action taken in good faith under this Subsection (3).

100 (d) The department may disclose a financial record obtained from a financial institution
101 under this section only for the purpose of, and to the extent necessary in, verifying eligibility as
102 provided in this section and Section 26-40-105.

103 ~~[(4) The simplified enrollment and renewal process established under this section shall
104 be implemented by the department no later than July 1, 2012.]~~

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

106 **26-18-3.8. Utah's Premium Partnership For Health Insurance -- Medicaid waiver.**
107 The department shall seek federal approval of an amendment to the state's Utah
108 Premium Partnership for Health Insurance program to adjust the eligibility determination for
109 single adults and parents who have an offer of employer sponsored insurance. The amendment
110 shall:

111 (1) be within existing appropriations for the Utah Premium Partnership for Health
112 Insurance program; and

113 (2) provide that adults who are up to 200% of the federal poverty level are eligible for
114 premium subsidies in the Utah Premium Partnership for Health Insurance program.

115 Section 3. Section **26-33a-106.1** is amended to read:

116 **26-33a-106.1. Health care cost and reimbursement data.**

117 (1) (a) The committee shall, as funding is available, establish an advisory panel to
118 advise the committee on the development of a plan for the collection and use of health care
119 data pursuant to Subsection 26-33a-104(6) and this section.

120 (b) The advisory panel shall include:

- 121 (i) the chairman of the Utah Hospital Association;
- 122 (ii) a representative of a rural hospital as designated by the Utah Hospital Association;
- 123 (iii) a representative of the Utah Medical Association;
- 124 (iv) a physician from a small group practice as designated by the Utah Medical
- 125 Association;
- 126 (v) two representatives who are health insurers, appointed by the committee;
- 127 (vi) a representative from the Department of Health as designated by the executive
- 128 director of the department;
- 129 (vii) a representative from the committee;
- 130 (viii) a consumer advocate appointed by the committee;
- 131 (ix) a member of the House of Representatives appointed by the speaker of the House;
- 132 and
- 133 (x) a member of the Senate appointed by the president of the Senate.
- 134 (c) The advisory panel shall elect a chair from among its members, and shall be staffed
- 135 by the committee.
- 136 (2) (a) The committee shall, as funding is available:
- 137 (i) establish a plan for collecting data from data suppliers, as defined in Section
- 138 26-33a-102, to determine measurements of cost and reimbursements for risk adjusted episodes
- 139 of health care;
- 140 [~~(ii) assist the demonstration projects implemented by the Insurance Department~~
- 141 ~~pursuant to Section 31A-22-614.6, with access to cost data, reimbursement data, care process~~
- 142 ~~data, and provider service data necessary for the demonstration projects' research, statistical~~
- 143 ~~analysis, and quality improvement activities;]~~
- 144 [~~(A) notwithstanding Subsection 26-33a-108(1) and Section 26-33a-109;]~~
- 145 [~~(B) contingent upon approval by the committee; and]~~
- 146 [~~(C) subject to a contract between the department and the entity providing analysis for~~
- 147 ~~the demonstration project;]~~
- 148 [~~(iii)~~] (ii) share data regarding insurance claims and an individual's and small employer
- 149 group's health risk factor with insurers participating in the defined contribution market created
- 150 in Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, only to the extent
- 151 necessary for:

152 (A) [~~renewals of policies~~] establishing rates and prospective risk adjusting in the
153 defined contribution arrangement market; and

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

155 [~~(iv)~~] (iii) assist the Legislature and the public with awareness of, and the promotion
156 of, transparency in the health care market by reporting on:

157 (A) geographic variances in medical care and costs as demonstrated by data available
158 to the committee; and

159 (B) rate and price increases by health care providers:

160 (I) that exceed the Consumer Price Index - Medical as provided by the United States
161 Bureau of Labor statistics;

162 (II) as calculated yearly from June to June; and

163 (III) as demonstrated by data available to the committee.

164 (b) The plan adopted under this Subsection (2) shall include:

165 (i) the type of data that will be collected;

166 (ii) how the data will be evaluated;

167 (iii) how the data will be used;

168 (iv) the extent to which, and how the data will be protected; and

169 (v) who will have access to the data.

170 Section 4. Section **26-33a-106.5** is amended to read:

171 **26-33a-106.5. Comparative analyses.**

172 (1) The committee may publish compilations or reports that compare and identify
173 health care providers or data suppliers from the data it collects under this chapter or from any
174 other source.

175 (2) (a) The committee shall publish compilations or reports from the data it collects
176 under this chapter or from any other source which:

177 (i) contain the information described in Subsection (2)(b); and

178 (ii) compare and identify by name at least a majority of the health care facilities and
179 institutions in the state.

180 (b) The report required by this Subsection (2) shall:

181 (i) be published at least annually; and

182 (ii) contain comparisons based on at least the following factors:

183 (A) nationally or other generally recognized quality standards;

184 (B) charges; and

185 (C) nationally recognized patient safety standards.

186 (3) The committee may contract with a private, independent analyst to evaluate the
187 standard comparative reports of the committee that identify, compare, or rank the performance
188 of data suppliers by name. The evaluation shall include a validation of statistical
189 methodologies, limitations, appropriateness of use, and comparisons using standard health
190 services research practice. The analyst shall be experienced in analyzing large databases from
191 multiple data suppliers and in evaluating health care issues of cost, quality, and access. The
192 results of the analyst's evaluation shall be released to the public before the standard
193 comparative analysis upon which it is based may be published by the committee.

194 (4) The committee shall adopt by rule a timetable for the collection and analysis of data
195 from multiple types of data suppliers.

196 (5) The comparative analysis required under Subsection (2) shall be available:

197 (a) free of charge and easily accessible to the public; and

198 (b) on the Health Insurance Exchange either directly or through a link.

199 (6) (a) ~~[On or before December 1, 2011, the]~~ The department shall include in the report
200 required by Subsection (2)(b), or include in a separate report, comparative information on
201 commonly recognized or generally agreed upon measures of quality identified in accordance
202 with Subsection (7), for:

203 (i) routine and preventive care; and

204 (ii) the treatment of diabetes, heart disease, and other illnesses or conditions.

205 (b) The comparative information required by Subsection (6)(a) shall be based on data
206 collected under Subsection (2) and clinical data that may be available to the committee, and
207 shall ~~[be reported as a statewide aggregate for facilities and clinics.]~~ beginning on or after July
208 1, 2012, compare:

209 ~~[(c) The department shall, in accordance with Subsection (7)(c), publish reports on or~~
210 ~~after July 1, 2012, based on the quality measures described in Subsection (6)(a), using the data~~
211 ~~collected under Subsection (2) and clinical data that may be available to the committee, that~~
212 ~~compare:]~~

213 (i) results for health care facilities or institutions;

214 (ii) a clinic's aggregate results for a physician who practices at a clinic with five or
215 more physicians; and

216 (iii) a geographic region's aggregate results for a physician who practices at a clinic
217 with less than five physicians, unless the physician requests physician-level data to be
218 published on a clinic level.

219 ~~(c)~~ (c) The department:

220 (i) may publish information required by this Subsection (6) directly or through one or
221 more nonprofit, community-based health data organizations;

222 (ii) may use a private, independent analyst under Subsection (3) in preparing the report
223 required by this section; and

224 (iii) shall identify and report to the Legislature's Health and Human Services Interim
225 Committee by July 1, 2012, and every July 1, thereafter until July 1, 2015, at least five new
226 measures of quality to be added to the report each year.

227 ~~(d)~~ (d) A report published by the department under this Subsection (6):

228 (i) is subject to the requirements of Section 26-33a-107; and

229 (ii) shall, prior to being published by the department, be submitted to a neutral,
230 non-biased entity with a broad base of support from health care payers and health care
231 providers in accordance with Subsection (7) for the purpose of validating the report.

232 (7) (a) The Health Data Committee shall, through the department, for purposes of
233 Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral,
234 non-biased entity with a broad base of support from health care payers and health care
235 providers.

236 (b) If the entity described in Subsection (7)(a) does not submit the quality measures
237 ~~[prior to July 1, 2011]~~, the department may select the appropriate number of quality measures
238 for purposes of the report required by Subsection (6).

239 (c) (i) For purposes of the reports published on or after July 1, 2012, the department
240 may not compare individual facilities or clinics as described in Subsections (6)~~(c)~~(b)(i)
241 through (iii) if the department determines that the data available to the department can not be
242 appropriately validated, does not represent nationally recognized measures, does not reflect the
243 mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing
244 providers.

245 (ii) The department shall report to the Legislature's Executive Appropriations
246 Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).

247 ~~[(d) The committee and the department shall report to the Legislature's Health System~~
248 ~~Reform Task Force on or before November 1, 2011, regarding the department's progress in~~
249 ~~creating a system to validate the data and address the issues described in Subsection(7)(c).]~~

250 Section 5. Section **26-40-106** is amended to read:

251 **26-40-106. Program benefits.**

252 (1) Until the department implements a plan under Subsection (2), program benefits
253 may include:

254 (a) hospital services;

255 (b) physician services;

256 (c) laboratory services;

257 (d) prescription drugs;

258 (e) mental health services;

259 (f) basic dental services;

260 (g) preventive care including:

261 (i) routine physical examinations;

262 (ii) immunizations;

263 (iii) basic vision services; and

264 (iv) basic hearing services;

265 (h) limited home health and durable medical equipment services; and

266 (i) hospice care.

267 (2) (a) Except as provided in Subsection (2)(d), no later than July 1, 2008, the medical
268 program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, to be
269 actuarially equivalent to a health benefit plan with the largest insured commercial enrollment
270 offered by a health maintenance organization in the state.

271 (b) Except as provided in Subsection (2)(d), after July 1, ~~[2008]~~ 2012:

272 (i) medical program benefits may not exceed the benefit level described in Subsection
273 (2)(a); and

274 (ii) medical program benefits shall be adjusted every July 1, thereafter to meet the
275 benefit level described in Subsection (2)(a).

276 (c) The dental benefit plan shall be benchmarked, in accordance with the Children's
277 Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit
278 plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is
279 offered in the state, except that the utilization review mechanism for orthodontia shall be based
280 on medical necessity. Dental program benefits shall be adjusted on July 1, 2012, and on July 1
281 every three years thereafter to meet the benefit level required by this Subsection (2)(c).

282 (d) The program benefits for enrollees who are at or below 100% of the federal poverty
283 level are exempt from the benchmark requirements of Subsections (2)(a) and (2)(b).

284 Section 6. Section **31A-22-613.5** is amended to read:

285 **31A-22-613.5. Price and value comparisons of health insurance.**

286 (1) (a) This section applies to all health benefit plans.

287 (b) Subsection (2) applies to:

288 (i) all health benefit plans; and

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

290 (2) (a) The commissioner shall promote informed consumer behavior and responsible
291 health benefit plans by requiring an insurer issuing a health benefit plan to:

292 (i) provide to all enrollees, prior to enrollment in the health benefit plan written
293 disclosure of:

294 (A) restrictions or limitations on prescription drugs and biologics including:

295 (I) the use of a formulary;

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

297 (III) requirements for generic substitution;

298 (B) coverage limits under the plan; and

299 (C) any limitation or exclusion of coverage including:

300 (I) a limitation or exclusion for a secondary medical condition related to a limitation or
301 exclusion from coverage; and

302 (II) easily understood examples of a limitation or exclusion of coverage for a secondary
303 medical condition; and

304 (ii) provide the commissioner with:

305 (A) the information described in Subsections 31A-22-635(5) through (7) in the
306 standardized electronic format required by Subsection 63M-1-2506(1); and

307 (B) information regarding insurer transparency in accordance with Subsection (4).
308 (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to
309 the commissioner:
310 (i) upon commencement of operations in the state; and
311 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
312 (A) treatment policies;
313 (B) practice standards;
314 (C) restrictions;
315 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
316 (E) limitations or exclusions of coverage including a limitation or exclusion for a
317 secondary medical condition related to a limitation or exclusion of the insurer's health
318 insurance plan.
319 (c) An insurer shall provide the enrollee with notice of an increase in costs for
320 prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):
321 (i) either:
322 (A) in writing; or
323 (B) on the insurer's website; and
324 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
325 soon as reasonably possible.
326 (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make
327 available to prospective enrollees and maintain evidence of the fact of the disclosure of:
328 (i) the drugs included;
329 (ii) the patented drugs not included;
330 (iii) any conditions that exist as a precedent to coverage; and
331 (iv) any exclusion from coverage for secondary medical conditions that may result
332 from the use of an excluded drug.
333 (e) (i) The commissioner shall develop examples of limitations or exclusions of a
334 secondary medical condition that an insurer may use under Subsection (2)(a)(i)(C).
335 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
336 (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact
337 situation to fall within the description of an example does not, by itself, support a finding of

338 coverage.

339 (3) The commissioner:

340 (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to
341 the Health Insurance Exchange created under Section 63M-1-2504; and

342 (b) may request information from an insurer to verify the information submitted by the
343 insurer under this section.

344 (4) The commissioner shall:

345 (a) convene a group of insurers, a member representing the Public Employees' Benefit
346 and Insurance Program, consumers, and an organization [~~described in Subsection~~
347 ~~31A-22-614.6(3)(b)~~] that provides multipayer and multiprovider quality assurance and data
348 collection, to develop information for consumers to compare health insurers and health benefit
349 plans on the Health Insurance Exchange, which shall include consideration of:

350 (i) the number and cost of an insurer's denied health claims;

351 (ii) the cost of denied claims that is transferred to providers;

352 (iii) the average out-of-pocket expenses incurred by participants in each health benefit
353 plan that is offered by an insurer in the Health Insurance Exchange;

354 (iv) the relative efficiency and quality of claims administration and other administrative
355 processes for each insurer offering plans in the Health Insurance Exchange; and

356 (v) consumer assessment of each insurer or health benefit plan;

357 (b) adopt an administrative rule that establishes:

358 (i) definition of terms;

359 (ii) the methodology for determining and comparing the insurer transparency
360 information;

361 (iii) the data, and format of the data, that an insurer shall submit to the commissioner in
362 order to facilitate the consumer comparison on the Health Insurance Exchange in accordance
363 with Section 63M-1-2506; and

364 (iv) the dates on which the insurer shall submit the data to the commissioner in order
365 for the commissioner to transmit the data to the Health Insurance Exchange in accordance with
366 Section 63M-1-2506; and

367 (c) implement the rules adopted under Subsection (4)(b) in a manner that protects the
368 business confidentiality of the insurer.

369 Section 7. Section **31A-30-106.1** is amended to read:

370 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

371 (1) Premium rates for small employer health benefit plans under this chapter are
372 subject to this section.

373 (2) (a) The index rate for a rating period for any class of business may not exceed the
374 index rate for any other class of business by more than 20%.

375 (b) For a class of business, the premium rates charged during a rating period to covered
376 insureds with similar case characteristics for the same or similar coverage, or the rates that
377 could be charged to an employer group under the rating system for that class of business, may
378 not vary from the index rate by more than 30% of the index rate, except when catastrophic
379 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

380 (3) The percentage increase in the premium rate charged to a covered insured for a new
381 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
382 the following:

383 (a) the percentage change in the new business premium rate measured from the first
384 day of the prior rating period to the first day of the new rating period;

385 (b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
386 of less than one year, due to the claim experience, health status, or duration of coverage of the
387 covered individuals as determined from the small employer carrier's rate manual for the class of
388 business, except when catastrophic mental health coverage is selected as provided in
389 Subsection 31A-22-625(2)(d); and

390 (c) any adjustment due to change in coverage or change in the case characteristics of
391 the covered insured as determined for the class of business from the small employer carrier's
392 rate manual.

393 (4) (a) Adjustments in rates for claims experience, health status, and duration from
394 issue may not be charged to individual employees or dependents.

395 (b) Rating adjustments and factors, including case characteristics, shall be applied
396 uniformly and consistently to the rates charged for all employees and dependents of the small
397 employer.

398 (c) Rating factors shall produce premiums for identical groups that:

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

400 (ii) do not reflect differences due to the nature of the groups assumed to select
401 particular health benefit products.

402 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the
403 same calendar month as having the same rating period.

404 (5) A health benefit plan that uses a restricted network provision may not be considered
405 similar coverage to a health benefit plan that does not use a restricted network provision,
406 provided that use of the restricted network provision results in substantial difference in claims
407 costs.

408 (6) The small employer carrier may not use case characteristics other than the
409 following:

410 (a) age of the employee, in accordance with Subsection (7);

411 (b) geographic area;

412 (c) family composition in accordance with Subsection (9);

413 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee and
414 spouse; [~~and~~]

415 (e) for an individual age 65 and older, whether the employer policy is primary or
416 secondary to Medicare[-]; and

417 (f) for small employer group coverage, group participation in a wellness program,
418 limited to a discount that does not exceed 10% of the premium for the small employer group.

419 (7) Age limited to:

420 (a) the following age bands:

421 (i) less than 20;

422 (ii) 20-24;

423 (iii) 25-29;

424 (iv) 30-34;

425 (v) 35-39;

426 (vi) 40-44;

427 (vii) 45-49;

428 (viii) 50-54;

429 (ix) 55-59;

430 (x) 60-64; and

- 431 (xi) 65 and above; and
- 432 (b) a standard slope ratio range for each age band, applied to each family composition
- 433 tier rating structure under Subsection (9)(b):
- 434 (i) as developed by the commissioner by administrative rule; and
- 435 (ii) not to exceed an overall ratio as provided in Subsection (8).
- 436 (8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:
- 437 (i) 5:1 for plans renewed or effective before January 1, 2012; and
- 438 (ii) 6:1 for plans renewed or effective on or after January 1, 2012; and
- 439 (b) the age slope ratios for each age band may not overlap.
- 440 (9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:
- 441 (a) an overall ratio of:
- 442 (i) 5:1 or less for plans renewed or effective before January 1, 2012; and
- 443 (ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and
- 444 (b) a tier rating structure that includes:
- 445 (i) four tiers that include:
- 446 (A) employee only;
- 447 (B) employee plus spouse;
- 448 (C) employee plus a child or children; and
- 449 (D) a family, consisting of an employee plus spouse, and a child or children;
- 450 (ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:
- 451 (A) employee only;
- 452 (B) employee plus spouse;
- 453 (C) employee plus one child;
- 454 (D) employee plus two or more children; and
- 455 (E) employee plus spouse plus one or more children; or
- 456 (iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:
- 457 (A) employee only;
- 458 (B) employee plus spouse;
- 459 (C) employee plus one child;
- 460 (D) employee plus two or more children;
- 461 (E) employee plus spouse plus one child; and

462 (F) employee plus spouse plus two or more children.

463 (10) If a health benefit plan is a health benefit plan into which the small employer
464 carrier is no longer enrolling new covered insureds, the small employer carrier shall use the
465 percentage change in the base premium rate, provided that the change does not exceed, on a
466 percentage basis, the change in the new business premium rate for the most similar health
467 benefit product into which the small employer carrier is actively enrolling new covered
468 insureds.

469 (11) (a) A covered carrier may not transfer a covered insured involuntarily into or out
470 of a class of business.

471 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
472 of business unless the offer is made to transfer all covered insureds in the class of business
473 without regard to:

- 474 (i) case characteristics;
- 475 (ii) claim experience;
- 476 (iii) health status; or
- 477 (iv) duration of coverage since issue.

478 (12) (a) Each small employer carrier shall maintain at the small employer carrier's
479 principal place of business a complete and detailed description of its rating practices and
480 renewal underwriting practices, including information and documentation that demonstrate that
481 the small employer carrier's rating methods and practices are:

- 482 (i) based upon commonly accepted actuarial assumptions; and
- 483 (ii) in accordance with sound actuarial principles.

484 (b) (i) Each small employer carrier shall file with the commissioner on or before April
485 1 of each year, in a form and manner and containing information as prescribed by the
486 commissioner, an actuarial certification certifying that:

- 487 (A) the small employer carrier is in compliance with this chapter; and
- 488 (B) the rating methods of the small employer carrier are actuarially sound.

489 (ii) A copy of the certification required by Subsection (12)(b)(i) shall be retained by the
490 small employer carrier at the small employer carrier's principal place of business.

491 (c) A small employer carrier shall make the information and documentation described
492 in this Subsection (12) available to the commissioner upon request.

493 (13) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter
494 3, Utah Administrative Rulemaking Act, to:

495 (i) implement this chapter; and

496 (ii) assure that rating practices used by small employer carriers under this section and
497 carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this
498 chapter.

499 (b) The rules may:

500 (i) assure that differences in rates charged for health benefit plans by carriers are
501 reasonable and reflect objective differences in plan design, not including differences due to the
502 nature of the groups or individuals assumed to select particular health benefit plans; and

503 (ii) prescribe the manner in which case characteristics may be used by small employer
504 and individual carriers.

505 (14) Records submitted to the commissioner under this section shall be maintained by
506 the commissioner as protected records under Title 63G, Chapter 2, Government Records
507 Access and Management Act.

508 Section 8. Section **31A-30-116** is enacted to read:

509 **31A-30-116. Essential health benefits.**

510 (1) For purposes of this section, the "Affordable Care Act" is as defined in Section
511 31A-2-212 and includes federal rules related to the offering of essential health benefits.

512 (2) The state chooses to designate its own essential health benefits rather than accept a
513 federal determination of the essential health benefits required to be offered in the individual
514 and small group market for plans renewed or offered on or after January 1, 2014.

515 (3) (a) Subject to Subsections (3)(b) and (c), to the extent required by the Affordable
516 Care Act, and after considering public testimony, the Legislature's Health System Reform Task
517 Force shall recommend to the commissioner, no later than September 1, 2012, a benchmark
518 plan for the state's essential health benefits based on:

519 (i) the largest plan by enrollment in any of the three largest small employer group
520 insurance products in the state's small employer group market;

521 (ii) any of the largest three state employee health benefit plans by enrollment;

522 (iii) the largest insured commercial non-Medicaid health maintenance organization
523 operating in the state; or

524 (iv) other benchmarks required or permitted by the Affordable Care Act.
525 (b) Notwithstanding the provisions of Subsection 63M-1-2505.5(2), based on the
526 recommendation of the task force under Subsection (3)(a), and within 30 days of the task force
527 recommendation, the commissioner shall adopt an emergency administrative rule that
528 designates the essential health benefits that shall be included in a plan offered or renewed on or
529 after January 1, 2014, in the small employer group and individual markets.

530 (c) The essential health benefit plan:
531 (i) shall not include a state mandate if the inclusion of the state mandate would require
532 the state to contribute to premium subsidies under the Affordable Care Act; and
533 (ii) may add benefits in addition to the benefits included in a benchmark plan described
534 in Subsection (3)(b) if the additional benefits are mandated under the Affordable Care Act.

535 Section 9. Section **63I-2-231** is amended to read:
536 **63I-2-231. Repeal dates, Title 31A.**
537 Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed [~~January 1,~~
538 ~~2013~~] July 1, 2013.

539 Section 10. Section **63M-1-2504** is amended to read:
540 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
541 (1) There is created within the Governor's Office of Economic Development the Office
542 of Consumer Health Services.
543 (2) The office shall:
544 (a) in cooperation with the Insurance Department, the Department of Health, and the
545 Department of Workforce Services, and in accordance with the electronic standards developed
546 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:
547 (i) provides information to consumers about private and public health programs for
548 which the consumer may qualify;
549 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
550 on the Health Insurance Exchange; and
551 (iii) includes information and a link to enrollment in premium assistance programs and
552 other government assistance programs;
553 (b) contract with one or more private vendors for:
554 (i) administration of the enrollment process on the Health Insurance Exchange,

555 including establishing a mechanism for consumers to compare health benefit plan features on
556 the exchange and filter the plans based on consumer preferences;

557 (ii) the collection of health insurance premium payments made for a single policy by
558 multiple payers, including the policyholder, one or more employers of one or more individuals
559 covered by the policy, government programs, and others; and

560 (iii) establishing a call center in accordance with Subsection (3);

561 (c) assist employers with a free or low cost method for establishing mechanisms for the
562 purchase of health insurance by employees using pre-tax dollars;

563 (d) establish a list on the Health Insurance Exchange of insurance producers who, in
564 accordance with Section 31A-30-209, are appointed producers for the Health Insurance
565 Exchange; and

566 (e) report to the Business and Labor Interim Committee and the Health System Reform
567 Task Force [~~prior to November 1, 2011, and~~] prior to the Legislative interim day in November
568 of each year [~~thereafter~~] regarding the operations of the Health Insurance Exchange required by
569 this chapter.

570 (3) A call center established by the office:

571 (a) shall provide unbiased answers to questions concerning exchange operations, and
572 plan information, to the extent the plan information is posted on the exchange by the insurer;
573 and

574 (b) may not:

575 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

576 (ii) [~~beginning July 1, 2011,~~] receive producer compensation through the Health
577 Insurance Exchange; and

578 (iii) [~~beginning July 1, 2011,~~] be designated as the default producer for an employer
579 group that enters the Health Insurance Exchange without a producer.

580 (4) The office:

581 (a) may not:

582 (i) regulate health insurers, health insurance plans, health insurance producers, or
583 health insurance premiums charged in the exchange;

584 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

585 (iii) act as an appeals entity for resolving disputes between a health insurer and an

586 insured;

587 (b) may establish and collect a fee for the cost of the exchange transaction in
588 accordance with Section 63J-1-504 for:

589 [~~(i) the transaction cost of:~~]

590 [~~(A)~~] (i) processing an application for a health benefit plan;

591 [~~(B)~~] (ii) accepting, processing, and submitting multiple premium payment sources;

592 [~~and~~]

593 [~~(C)~~] (iii) providing a mechanism for consumers to filter and compare health benefit
594 plans in the exchange based on consumer preferences; and

595 [~~(ii)~~] (iv) funding the call center [~~established in accordance with Subsection (3)~~]; and

596 (c) shall separately itemize [~~any fees~~] the fee established under Subsection (4)(b) as
597 part of the cost displayed for the employer selecting coverage on the exchange.

598 Section 11. **Repealer.**

599 This bill repeals:

600 Section **26-1-39, Health System Reform Demonstration Projects.**

601 Section **31A-22-614.6, Health care delivery and payment reform demonstration**
602 **projects.**

603 Section 12. **Health System Reform Task Force -- Creation -- Membership --**

604 **Interim rules followed -- Compensation -- Staff.**

605 (1) There is created the Health System Reform Task Force consisting of the following
606 11 members:

607 (a) four members of the Senate appointed by the president of the Senate, no more than
608 three of whom may be from the same political party; and

609 (b) seven members of the House of Representatives appointed by the speaker of the
610 House of Representatives, no more than five of whom may be from the same political party.

611 (2) (a) The president of the Senate shall designate a member of the Senate appointed
612 under Subsection (1)(a) as a cochair of the committee.

613 (b) The speaker of the House of Representatives shall designate a member of the House
614 of Representatives appointed under Subsection (1)(b) as a cochair of the committee.

615 (3) In conducting its business, the committee shall comply with the rules of legislative
616 interim committees.

617 (4) Salaries and expenses of the members of the committee shall be paid in accordance
618 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
619 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
620 Sessions.

621 (5) The Office of Legislative Research and General Counsel shall provide staff support
622 to the committee.

623 Section 13. **Duties -- Interim report.**

624 (1) The committee shall review and make recommendations on the following issues:

625 (a) the state's response to federal health care reform;

626 (b) health coverage for children in the state;

627 (c) the role and regulation of navigators assisting individuals with the selection and
628 purchase of health benefit plans;

629 (d) health insurance plans available on the Utah Health Exchange, including dental and
630 vision plans;

631 (e) the governance structure of the Utah Health Exchange, including advisory boards
632 for the Utah Health Exchange or any other health exchange developed in the state;

633 (f) no later than September 1, 2012, a recommendation to the Insurance Commissioner
634 regarding a benchmark plan for the essential health benefit plan in the individual and small
635 employer group market in the state;

636 (g) the risk adjustment mechanism for the health exchange and methods to develop and
637 administer a risk adjustment system that limits the administrative burden on government and
638 health insurance plans, and creates stability in the insurance market;

639 (h) whether the state should consider developing and offering a basic health plan in
640 2014 to provide coverage options for individuals from 133% to 200% of the federal poverty
641 level;

642 (i) strategies to manage Medicaid expansion in 2014, including whether the Medicaid
643 benefit plan should be the same as, or different from, the essential health benefit plan in the
644 private insurance market;

645 (j) cost containment strategies for health care, including durable medical equipment
646 and home health care cost containment strategies;

647 (k) analysis of cost effective bariatric surgery coverage; and

648 (1) Medicaid behavioral and mental health delivery and payment reform models,
649 including:

650 (i) identifying and eliminating barriers to the delivery of effective mental, behavioral,
651 and physical health care delivery systems;

652 (ii) the costs and financing of mental and behavioral health care, including current cost
653 drivers, cost shifting, cost containment measures, and the roles of local government programs,
654 state government programs, and federal government programs; and

655 (iii) innovative service delivery models that facilitate access to quality, cost effective
656 and coordinated mental, behavioral, and physical health care.

657 (2) A final report, including any proposed legislation shall be presented to the Health
658 and Human Services and Business and Labor Interim Committees before November 30, 2012.

659 **Section 14. Appropriation.**

660 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, the
661 following sums of money are appropriated from resources not otherwise appropriated, or
662 reduced from amounts previously appropriated, out of the funds or accounts indicated for the
663 fiscal year beginning July 1, 2011 and ending June 30, 2012. These are additions to any
664 amounts previously appropriated for fiscal year 2012.

665 To Legislature - Senate

666 From General Fund, One-time \$15,000

667 Schedule of Programs:

668 Administration \$15,000

669 To Legislature - House of Representatives

670 From General Fund, One-time \$25,000

671 Schedule of Programs:

672 Administration \$25,000

673 **Section 15. Repeal date.**

674 The Health System Reform Task Force is repealed December 31, 2012.

Legislative Review Note
as of 2-3-12 10:04 AM

Office of Legislative Research and General Counsel