HEALTH REFORM AMENDMENTS

2017 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill amends and enacts code sections related to health care insurance and the health care insurance market.

Highlighted Provisions:

This bill:

- amends definitions for the Insurance Code;
- effective January 1, 2018, merges the regulation of health insurance plans that are offered by managed care organizations into a managed care organization chapter of the Insurance Code;
- amends the duties of the Office of Consumer Health Services within the Governor's Office of Economic Development to require the office to wind down the small employer health insurance exchange known as Avenue H;
- removes health plan transparency reporting requirements for plans offered on the small employer health insurance exchange;
- repeals the defined contribution arrangements and the individual and small employer risk adjustment, which are part of the small employer health insurance exchange, effective July 1, 2019;
- reauthorizes the Health Reform Task Force for two years;
- establishes the duties of the task force; and
- makes technical amendments and conforming amendments.

Money Appropriated in this Bill:

This bill appropriates for fiscal year 2017:

- to Legislature - Senate as a one-time appropriation:
  - from the General Fund, One-time, $20,000;
- to Legislature - House of Representatives as a one-time appropriation:
  - from the General Fund, One-time, $34,000.

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

26-19-14, as last amended by Laws of Utah 1995, Chapter 102

31A-1-301, as last amended by Laws of Utah 2016, Chapter 138

31A-2-201.2, as last amended by Laws of Utah 2015, Chapter 283

31A-4-115, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

31A-8-101, as last amended by Laws of Utah 2002, Chapter 308

31A-8-103, as last amended by Laws of Utah 2010, Chapter 324

31A-21-106, as last amended by Laws of Utah 2003, Chapter 252

31A-22-610.1, as last amended by Laws of Utah 2014, Chapter 353

31A-22-610.5, as last amended by Laws of Utah 2011, Chapter 297

31A-22-613.5, as last amended by Laws of Utah 2015, Chapters 257 and 283

31A-22-618, as last amended by Laws of Utah 2015, Chapter 367

31A-22-618.5, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-22-627, as last amended by Laws of Utah 2016, Chapter 295

31A-22-628, as enacted by Laws of Utah 2000, Chapter 37

31A-22-635, as last amended by Laws of Utah 2015, Chapter 283

31A-22-642, as enacted by Laws of Utah 2014, Chapter 379

31A-23a-402, as last amended by Laws of Utah 2015, Chapters 244 and 283

31A-30-102, as last amended by Laws of Utah 2015, Chapter 283

31A-30-104, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-30-106.7, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-30-204, as last amended by Laws of Utah 2015, Chapter 283

31A-34-110, as last amended by Laws of Utah 2001, Chapter 108

49-20-407, as last amended by Laws of Utah 2012, Chapter 127

53-2a-1102, as last amended by Laws of Utah 2015, Chapter 408

58-16a-601, as last amended by Laws of Utah 2014, Chapter 305

63I-2-231, as last amended by Laws of Utah 2016, Chapter 138

63N-11-104, as renumbered and amended by Laws of Utah 2015, Chapter 283

ENACTS:

31A-45-101, Utah Code Annotated 1953

31A-45-102, Utah Code Annotated 1953

31A-45-103, Utah Code Annotated 1953

31A-45-201, Utah Code Annotated 1953

31A-45-301, Utah Code Annotated 1953

31A-45-302, Utah Code Annotated 1953

31A-45-402, Utah Code Annotated 1953

RENUMBERS AND AMENDS:

31A-22-618.6, (Renumbered from 31A-8-402.3, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425)

31A-22-618.7, (Renumbered from 31A-8-402.5, as last amended by Laws of Utah 2003, Chapter 252)

31A-22-618.8, (Renumbered from 31A-8-402.7, as last amended by Laws of Utah 2005, Chapter 78)

31A-45-303, (Renumbered from 31A-22-617, as last amended by Laws of Utah 2014, Chapters 290 and 300)

31A-45-304, (Renumbered from 31A-22-617.1, as enacted by Laws of Utah 2005, First Special Session, Chapter 3)

31A-45-401, (Renumbered from 31A-8-502, as enacted by Laws of Utah 2004, Chapter 178)

31A-45-501, (Renumbered from 31A-8-501, as last amended by Laws of Utah 2012, Chapter 369)

REPEALS:

31A-22-721, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

31A-30-107, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425

31A-30-107.1, as last amended by Laws of Utah 2003, Chapter 252

31A-30-107.3, as last amended by Laws of Utah 2013, Chapter 341

31A-30-116, as last amended by Laws of Utah 2016, Chapter 138

63N-11-107, as renumbered and amended by Laws of Utah 2015, Chapter 283

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

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

Section 1. Section **26-19-14** is amended to read:

26-19-14. Insurance policies not to deny or reduce benefits of persons eligible for state medical assistance -- Exemptions.

(1) A policy of accident or sickness insurance [~~issued or renewed after May 12, 1981,~~] may not contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving medical assistance from the state.

(2) [~~After May 12, 1981, no~~] An association, corporation, or organization may not deliver, issue for delivery, or renew any subscriber's contract which contains any provisions denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance from the state.

(3) [~~After May 12, 1981, no~~] An association, corporation, business, or organization authorized to do business in this state and which provides or pays for any health care benefits may not deny or reduce benefits because services are rendered to a beneficiary who is eligible for or receiving medical assistance from the state.

(4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees

Health Program, administered by the Utah State Retirement Board, is not required to reimburse any agency of state government for custodial care which the agency provides, through its staff or facilities, to members of the Utah State Public Employees Health Program.

[~~(5) This section is subject to the provisions of Subsection 31A-22-610.5(3).~~]

Section 2. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" means the same as that term is defined in Subsection [~~(166)~~] (170).

(4) "Adult" means an individual who has attained the age of at least 18 years.

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of individuals manage the corporations.

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which an individual does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301, 31A-25-207, or 31A-26-209.

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

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

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more individuals if the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life.

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

(13) "Binder" means the same as that term is defined in Section 31A-21-102.

(14) "Blanket insurance policy" means a group policy covering a defined class of persons:

(a) without individual underwriting or application; and

(b) that is determined by definition without designating each person covered.

(15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

(16) "Bona fide office" means a physical office in this state:

(a) that is open to the public;

(b) that is staffed during regular business hours on regular business days; and

(c) at which the public may appear in person to obtain services.

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" means the same as that term is defined in Subsection [~~(89)~~] (91).

(19) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:

(a) Section 31A-7-201;

(b) Section 31A-8-205; or

(c) Subsection 31A-9-205(2).

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

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

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

(i) owned by the insureds; and

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

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

(23) "Certificate" means evidence of insurance given to:

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

(b) a third party.

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

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

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

(27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent supervisory official of another jurisdiction.

(28) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection (28)(a) under an agreement effective:

(A) for the life of the insured; or

(B) for a period in excess of one year.

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

(29) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (29)(a)(i) through (iii).

(b) There is no presumption that an individual holding an official position with another person controls that person solely by reason of the position.

(c) A person having a contract or arrangement giving control is considered to have control despite the illegality or invalidity of the contract or arrangement.

(d) There is a rebuttable presumption of control in a person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting securities of another person.

(30) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

(31) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(32) "Controlling producer" means a producer who directly or indirectly controls an insurer.

(33) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

[~~(c)~~] (b) "Mutual" or "mutual corporation" means a mutual insurance corporation.

[~~(b)~~] (c) "Stock corporation" means a stock insurance corporation.

(34) (a) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

(b) "Creditable coverage" includes coverage that is offered through a public health plan such as:

(i) the Primary Care Network Program under a Medicaid primary care network demonstration waiver obtained subject to Section 26-18-3;

(ii) the Children's Health Insurance Program under Section 26-40-106; or

(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No. 109-415.

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

indemnity for payments coming due on a specific loan or other credit transaction while the debtor has a disability.

(36) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(39) "Credit property insurance" means insurance:

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

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

(40) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

(41) (a) "Crop insurance" means insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils that is:

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

(b) "Crop insurance" includes multiperil crop insurance.

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

(43) "Deadline" means a final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

(44) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is considered to have taken a specific action. If the statute so provides, a condition precedent may be the commissioner's failure to take a specific action.

(45) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

(46) "Department" means the Insurance Department.

(47) "Director" means a member of the board of directors of a corporation.

(48) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

(ii) an occupation for which the individual is reasonably suited by education, training, or experience; or

(b) perform two or more of the following basic activities of daily living:

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(49) "Disability income insurance" means the same as that term is defined in Subsection [~~(80)~~] (82).

(50) "Domestic insurer" means an insurer organized under the laws of this state.

(51) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

(c) in the case of an alien insurer, enters into the United States.

(52) (a) "Eligible employee" means:

(i) an employee who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; or

(ii) a person described in Subsection (52)(b).

(b) "Eligible employee" includes:

(i) an owner who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; and

(ii) if the individual is included under a health benefit plan of a small employer:

(A) a sole proprietor;

(B) a partner in a partnership; or

(C) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse who does not meet the requirements of Subsection (52)(a)(i); or

(iii) a dependent of an employer who does not meet the requirements of Subsection (52)(a)(i).

(53) "Employee" means:

(a) an individual employed by an employer; and

(b) an owner who meets the requirements of Subsection (52)(b)(i).

(54) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(55) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax revenues.

(56) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

(57) (a) "Enrollee" means:

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

(A) who has entered into a contract with an organization for health care; or

(B) on whose behalf an arrangement for health care has been made.

(b) "Enrollee" includes an insured.

[~~(57)~~] (58) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

(b) if there is a waiting period, the first day of the waiting period.

[~~(58)~~] (59) "Enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause:

(a) the insurer's risk-based capital to fall into an action or control level as set forth in

Sections 31A-17-601 through 31A-17-613; or

(b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.

[~~(59)~~] (60) (a) "Escrow" means:

(i) a transaction that effects the sale, transfer, encumbering, or leasing of real property, when a person not a party to the transaction, and neither having nor acquiring an interest in the title, performs, in accordance with the written instructions or terms of the written agreement between the parties to the transaction, any of the following actions:

(A) the explanation, holding, or creation of a document; or

(B) the receipt, deposit, and disbursement of money;

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

(i) the following notarial acts performed by a notary within the state:

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

(ii) the receipt or delivery of a document; or

(iii) the receipt of money for delivery to the escrow agent.

[~~(60)~~] (61) "Escrow agent" means an agency title insurance producer meeting the requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an individual title insurance producer licensed with an escrow subline of authority.

[~~(61)~~] (62) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for

use in interpretation of this title.

[~~(62)~~] (63) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

[~~(63)~~] (64) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

[~~(64)~~] (65) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

[~~(65)~~] (66) (a) "Filed" means that a filing is:

(i) submitted to the department as required by and in accordance with applicable statute, rule, or filing order;

(ii) received by the department within the time period provided in applicable statute, rule, or filing order; and

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(65)~~] (66)(a).

[~~(66)~~] (67) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

[~~(67)~~] (68) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

[~~(68)~~] (69) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(69)~~] (70) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

[~~(70)~~] (71) "Franchise insurance" means an individual insurance policy provided

through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(71)~~] (72) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(72)~~] (73);

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) another line of insurance that the commissioner considers necessary to recognize in the public interest.

[~~(72)~~] (73) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(73)~~] (74) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

[~~(74)~~] (75) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of a member of the group who is selected under a procedure defined in:

(A) the policy; or

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

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

[~~(75)~~] (76) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(76) (a) Except as provided in Subsection (76)(b), "health benefit plan" means a policy or certificate that:~~]

[~~(i) provides health care insurance;~~]

[~~(ii) provides major medical expense insurance; or~~]

[~~(iii) is offered as a substitute for hospital or medical expense insurance, such as:~~]

[~~(A) a hospital confinement indemnity; or~~]

[~~(B) a limited benefit plan.~~]

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

[~~(i) provides benefits solely for:~~]

[~~(A) accident;~~]

[~~(B) dental;~~]

[~~(C) income replacement;~~]

[~~(D) long-term care;~~]

[~~(E) a Medicare supplement;~~]

[~~(F) a specified disease;~~]

[~~(G) vision; or~~]

[~~(H) a short-term limited duration; or~~]

[~~(ii) is offered and marketed as supplemental health insurance.~~]

(77) (a) "Health benefit plan" means, except as provided in Subsection (77)(b), a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care.

(b) "Health benefit plan" does not include:

(i) coverage only for accident or disability income insurance, or any combination thereof;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

(viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(A) limited scope dental or vision benefits;

(B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(C) other similar limited benefits, specified in federal regulations issued pursuant to Pub. L. No. 104-191;

(x) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any health plan, and the benefits are paid with respect to an event without regard to whether benefits are provided under any health plan:

(A) coverage only for specified disease or illness; or

(B) hospital indemnity or other fixed indemnity insurance; and

(xi) the following if offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under the Social Security Act, 42 U.S.C. Sec. 1395ss(g)(1);

(B) coverage supplemental to the coverage provided under United States Code, Title 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

(C) similar supplemental coverage provided to coverage under a group health insurance plan.

[~~(77)~~] (78) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

[~~(78)~~] (79) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

(80) "Health care provider" means the same as that term is defined in Section 78B-3-403.

[~~(79)~~] (81) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

[~~(80)~~] (82) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(81)~~] (83) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(82)~~] (84) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

[~~(83)~~] (85) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(84)~~] (86) "Individual" means a natural person.

[~~(85)~~] (87) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

[~~(86)~~] (88) "Insolvency" means that:

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

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

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

[~~(87)~~] (89) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

[~~(88)~~] (90) "Insurance adjuster" means a person who directs or conducts 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.

[~~(89)~~] (91) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance by an organization that is or is required to be licensed under this title;

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

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

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

(c) providing an annuity:

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

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

(d) providing the characteristic services of a motor club as outlined in Subsection [~~(117)~~] (120);

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections [~~(89)~~] (91)(a) through (h) in a manner designed to evade this title.

[~~(90)~~] (92) "Insurance consultant" or "consultant" means a person who:

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

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

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

[~~(91)~~] (93) "Insurance holding company system" means a group of two or more

affiliated persons, at least one of whom is an insurer.

[~~(92)~~] (94) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) (i) "Producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that insurer.

(ii) "Producer for the insurer" may be referred to as an "agent."

(c) (i) "Producer for the insured" means a producer who:

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

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

(ii) "Producer for the insured" may be referred to as a "broker."

[~~(93)~~] (95) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection [~~(93)~~] (95)(a):

(i) applies only to this title; [~~and~~]

(ii) does not define the meaning of [~~this word~~] "insured" as used in an insurance policy or certificate[~~.~~]; and

(iii) includes an enrollee.

[~~(94)~~] (96) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

(ii) an issuer of a gift annuity other than an annuity specified in Subsections

31A-22-1305(2) and (3);

(iii) a motor club;

(iv) an employee welfare plan; [~~and~~]

(v) a person purporting or intending to do an insurance business as a principal on that person's own account[~~.~~]; and

(vi) a health maintenance organization.

(b) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.

[~~(95)~~] (97) "Interinsurance exchange" means the same as that term is defined in Subsection [~~(148)~~] (152).

[~~(96)~~] (98) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(97)~~] (99) (a) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(i) employed an average of at least 51 employees on business days during the preceding calendar year; and

(ii) employs at least one employee on the first day of the plan year.

(b) The number of employees shall be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2).

[~~(98)~~] (100) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(99)~~] (101) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

(a) on the earliest date on which coverage can become effective for the individual

under the terms of the plan; or

(b) through special enrollment.

[~~(100)~~] (102) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

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

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

[~~(101)~~] (103) (a) "Liability insurance" means insurance against liability:

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

(A) [~~Subsection (111) for~~] medical malpractice insurance;

(B) [~~Subsection (139) for~~] professional liability insurance; and

(C) [~~Subsection (175) for~~] workers' compensation insurance;

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

(A) [~~Subsection (111) for~~] medical malpractice insurance;

(B) [~~Subsection (139) for~~] professional liability insurance; and

(C) [~~Subsection (175) for~~] workers' compensation insurance;

(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

(iv) for loss or damage to property caused by:

(A) the breakage or leakage of a sprinkler, water pipe, or water container; or

(B) water entering through a leak or opening in a building; or

(v) for other loss or damage properly the subject of insurance not within another kind

of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

(iii) making inspection of, and issuing a certificate of inspection upon, an elevator, boiler, machinery, or apparatus of any kind when done in connection with insurance on the elevator, boiler, machinery, or apparatus.

[~~(102)~~] (104) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

(b) "License" includes a certificate of authority issued to an insurer.

[~~(103)~~] (105) (a) "Life insurance" means:

(i) insurance on a human life; and

(ii) insurance pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

(iv) granting an additional benefit in the event of death by accident;

(v) granting an additional benefit to safeguard the policy against lapse; and

(vi) providing an optional method of settlement of proceeds.

[~~(104)~~] (106) "Limited license" means a license that:

(a) is issued for a specific product of insurance; and

(b) limits an individual or agency to transact only for that product or insurance.

[~~(105)~~] (107) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) another form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

[~~(106)~~] (108) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

[~~(107)~~] (109) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

(k) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

[~~(108)~~] (110) "Limited lines authority" includes the lines of insurance listed in Subsection [~~(107)~~] (109).

[~~(109)~~] (111) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(110)~~] (112) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

(i) in a setting other than an acute care unit of a hospital;

(ii) for not less than 12 consecutive months for a covered person on the basis of:

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

(iii) for one or more necessary or medically necessary services that are:

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

(C) (I) a nonprofit health hospital; and

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(110)~~] (112)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

(b) "Long-term care insurance" includes:

(i) any of the following that provide directly or supplement long-term care insurance:

(A) a group or individual annuity or rider; or

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(113) "Managed care organization" means a person:

(a) licensed as a health maintenance organization under Chapter 8, Health Maintenance Organizations and Limited Health Plans; or

(b) (i) licensed under:

(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(C) Chapter 14, Foreign Insurers; and

(ii) that requires an enrollee to use, or offers incentives, including financial incentives, for an enrollee to use, network providers.

[~~(111)~~] (114) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

[~~(112)~~] (115) "Member" means a person having membership rights in an insurance corporation.

[~~(113)~~] (116) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(114)~~] (117) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor has a disability.

[~~(115)~~] (118) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

[~~(116)~~] (119) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(117)~~] (120) "Motor club" means a person:

(a) licensed under:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

(b) that promises for an advance consideration to provide for a stated period of time one or more:

(i) legal services under Subsection 31A-11-102(1)(b);

(ii) bail services under Subsection 31A-11-102(1)(c); or

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(117)~~] (120)(b)(iii)(A) through (D); or

(F) other services given in Subsections 31A-11-102(1)(b) through (f).

[~~(118)~~] (121) "Mutual" means a mutual insurance corporation.

[~~(119)~~] (122) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

(123) "Network provider" means a health care provider who has an agreement with a managed care organization to provide health care services to an enrollee with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the managed care organization.

[~~(120)~~] (124) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(121)~~] (125) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

(b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

(c) earnings such as freight, passage money, commissions, or profits derived from transporting goods or people upon or across the oceans or inland waterways; or

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors, owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

[~~(122)~~] (126) "Order" means an order of the commissioner.

[~~(123)~~] (127) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(124)~~] (128) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

[~~(125)~~] (129) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

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

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or

(ii) another government health benefit.

[~~(126)~~] (130) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

[~~(127)~~] (131) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

[~~(128)~~] (132) "Plan sponsor" [~~is as~~] means the same as that term is defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(129)~~] (133) "Plan year" means:

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

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

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

(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:

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

(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or

(iii) the employer's taxable year if:

(A) the plan does not impose deductibles or limits on a yearly basis; and

(B) (I) the plan is not insured; or

(II) the insurance policy is not renewed on an annual basis; or

(c) in a case not described in Subsection [~~(129)~~] (133)(a) or (b), the calendar year.

[~~(130)~~] (134) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

(b) "Policy" includes a service contract issued by:

(i) a motor club under Chapter 11, Motor Clubs;

(ii) a service contract provided under Chapter 6a, Service Contracts; and

(iii) a corporation licensed under:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

(c) "Policy" does not include:

(i) a certificate under a group insurance contract; or

(ii) a document that does not purport to have legal effect.

[~~(131)~~] (135) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(132)~~] (136) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(133)~~] (137) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(134)~~] (138) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance.

[~~(135)~~] (139) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that day; and

(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.

[~~(136)~~] (140) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

(c) (i) "Premium" does not include consideration paid to a third party administrator for the third party administrator's services.

(ii) "Premium" includes an amount paid by a third party administrator to an insurer for insurance on the risks administered by the third party administrator.

[~~(137)~~] (141) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(138)~~] (142) "Proceeding" includes an action or special statutory proceeding.

[~~(139)~~] (143) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(140)~~] (144) (a) Except as provided in Subsection [~~(140)~~] (144)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(141)~~] (145) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(142)~~] (146) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

[~~(143)~~] (147) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(144)~~] (148) (a) Except as provided in Subsection [~~(144)~~] (148)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

(iv) an individual serving as an actuarial or legal consultant.

[~~(145)~~] (149) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(146)~~] (150) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow, or give, directly or indirectly:

(i) a refund of premium or portion of premium;

(ii) a refund of commission or portion of commission;

(iii) a refund of all or a portion of a consultant fee; or

(iv) providing services or other benefits not specified in an insurance or annuity contract.

(b) "Rebate" does not include:

(i) a refund due to termination or changes in coverage;

(ii) a refund due to overcharges made in error by the licensee; or

(iii) savings or wellness benefits as provided in the contract by the licensee.

[~~(147)~~] (151) "Received by the department" means:

(a) the date delivered to and stamped received by the department, if delivered in person;

(b) the post mark date, if delivered by mail;

(c) the delivery service's post mark or pickup date, if delivered by a delivery service;

(d) the received date recorded on an item delivered, if delivered by:

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

[~~(148)~~] (152) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of the persons; and

(b) exchanging insurance contracts with one another that provide insurance coverage on each other.

[~~(149)~~] (153) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

(a) the insurer transferring the risk as the "ceding insurer"; and

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(150)~~] (154) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(151)~~] (155) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(152)~~] (156) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

(b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a

liability assumed under a reinsurance contract.

[~~(153)~~] (157) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(154)~~] (158) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(155)~~] (159) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in a profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(155)~~] (159)(a)(i) through (xiv); or

(xvi) another interest or instrument commonly known as a security.

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a

specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(156)~~] (160) "Securityholder" means a specified person who owns a security of a person, including:

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

(d) any other security convertible into or evidencing the right of any of the items listed in this Subsection [~~(156)~~] (160).

[~~(157)~~] (161) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(b) Except as provided in this Subsection [~~(157)~~] (161), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(c) "Self-insurance" includes:

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

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

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

[~~(158)~~] (162) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(159)~~] (163) "Short-term care insurance" means an insurance policy or rider

advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

[~~(160)~~] (164) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(161)~~] (165) (a) "Small employer" means, in connection with a health benefit plan and with respect to a calendar year and to a plan year, an employer who:

(i) employed at least one employee but not more than 50 employees on business days during the preceding calendar year; and

(ii) employs at least one employee on the first day of the plan year.

(b) The number of employees shall:

(i) be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2); and

(ii) include an owner described in Subsection (52)(b)(i).

(c) "Small employer" does not include a sole proprietor that does not employ at least one employee.

[~~(162)~~] (166) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

[~~(163)~~] (167) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(164)~~] (168) Subject to Subsection [~~(87)~~] (89)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(165)~~] (169) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of an insurer or organization that is designated by the insurer or organization as permanent.

(ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require that insurers or organizations doing business in this state maintain specified minimum levels of permanent surplus.

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

(c) "Excess surplus" means:

(i) for a life insurer, accident and health insurer, health organization, or property and casualty insurer as defined in Section 31A-17-601, the lesser of:

(A) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 2.5; and

(II) the sum of the insurer's or health organization's minimum capital or permanent surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

(B) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 3.0; and

(II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

(ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

(A) 1.5; and

(B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

[~~(166)~~] (170) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of

residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

(i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;

(ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

(iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under the following, but only for a line of insurance for which the insurer holds a license in this state:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

(iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt; or

(f) an institution, bank, or financial institution:

(i) that is:

(A) an institution whose deposits and accounts are to any extent insured by a federal deposit insurance agency, including the Federal Deposit Insurance Corporation or National

Credit Union Administration; or

(B) a bank or other financial institution that is subject to supervision or examination by a federal or state banking authority; and

(ii) that does not adjust claims without a third party administrator license.

[~~(167)~~] (171) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(168)~~] (172) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

(b) another item provided by the RBC instructions, as RBC instructions is defined in Section 31A-17-601.

[~~(169)~~] (173) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

[~~(170)~~] (174) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

(i) not holding a valid certificate of authority to do an insurance business in this state; or

(ii) transacting business not authorized by a valid certificate.

(b) "Admitted insurer" or "authorized insurer" means an insurer:

(i) holding a valid certificate of authority to do an insurance business in this state; and

(ii) transacting business as authorized by a valid certificate.

[~~(171)~~] (175) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(172)~~] (176) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection [~~(140)~~] (144).

[~~(173)~~] (177) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(174)~~] (178) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(175)~~] (179) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 3. Section **31A-2-201.2** is amended to read:

31A-2-201.2. Evaluation of health insurance market.

(1) Each year the commissioner shall:

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

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

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

(2) The evaluation required by this section shall:

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

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

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

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

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

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

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

[~~(a) the types of health benefit plans sold in the Health Insurance Exchange created in Section 63N-11-104;~~]

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

[~~(c) the number of employers and covered lives in the defined contribution arrangement market in the Health Insurance Exchange.~~]

[~~(4)~~] (3) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

[~~(5)~~] (4) The commissioner may adopt administrative rules for the purpose of

collecting the data required by this section, taking into account the business confidentiality of the insurers.

[~~(6)~~] (5) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Section 4. Section **31A-4-115** is amended to read:

31A-4-115. Plan of orderly withdrawal.

(1) (a) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, the insurer shall file with the commissioner a plan of orderly withdrawal.

(b) For purposes of this section, a discontinuance of a health benefit plan [~~pursuant to one of the following provisions~~] is a withdrawal from a line of insurance[~~: (i)~~] under [~~Subsection 31A-30-107(3)(c); or (ii) Subsection 31A-30-107.1(3)(c)~~] Subsections 31A-22-618.6(5) or 31A-22-618.7(3).

(2) An insurer's plan of orderly withdrawal shall:

(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to its Utah policyholders and claimants;

(iii) meeting applicable statutory obligations; and

(iv) the payment of a withdrawal fee of $50,000 to the department if the insurer's line of business is not assumed or placed with another insurer approved by the commissioner.

(3) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly withdrawal adequately demonstrates that the insurer will:

(a) protect the interests of the people of the state;

(b) meet the insurer's contractual obligations;

(c) provide service to the insurer's Utah policyholders and claimants; and

(d) meet applicable statutory obligations.

(4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

(5) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that:

(a) there is reasonable cause to conclude that the interests of the people of the state are best served by such action; and

(b) the insurer:

(i) has filed a plan of orderly withdrawal; or

(ii) intends to:

(A) withdraw from writing a line of insurance in this state; or

(B) reduce the insurer's total annual premium volume by 75% or more.

(6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

(a) withdraws from writing insurance in this state without receiving the commissioner's approval of a plan of orderly withdrawal; or

(b) reduces its total annual premium volume by 75% or more in any year without receiving the commissioner's approval of a plan of orderly withdrawal.

(7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years unless the commissioner finds that the prohibition should be waived because the waiver is:

(a) in the public interest to promote competition; or

(b) to resolve inequity in the marketplace.

(8) The commissioner shall adopt rules necessary to implement this section.

Section 5. Section **31A-8-101** is amended to read:

31A-8-101. Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:

(a) emergency care;

(b) inpatient hospital and physician care;

(c) outpatient medical services; and

(d) out-of-area coverage.

[~~(2) "Director of health" means:~~]

[~~(a) the executive director of the Department of Health; or~~]

[~~(b) the authorized representative of the executive director of the Department of Health.~~]

[~~(3) "Enrollee" means an individual:~~]

[~~(a) who has entered into a contract with an organization for health care; or~~]

[~~(b) in whose behalf an arrangement for health care has been made.~~]

[~~(4) "Health care" is as defined in Section 31A-1-301.~~]

[~~(5)~~] (2) "Health maintenance organization" means any person:

(a) other than:

(i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(ii) an individual who contracts to render professional or personal services that the individual directly performs; and

(b) that:

(i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and

(ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.

[~~(6)~~] (3) (a) "Limited health plan" means, except as limited under Subsection [~~(6)~~] (3)(b), [~~any~~] a person who furnishes dental or vision services, either directly or through arrangements with others[~~, services~~]:

[~~(i) of:~~]

[~~(A) dentists;~~]

[~~(B) optometrists;~~]

[~~(C) physical therapists;~~]

[~~(D) podiatrists;~~]

[~~(E) psychologists;~~]

[~~(F) physicians;~~]

[~~(G) chiropractic physicians;~~]

[~~(H) naturopathic physicians;~~]

[~~(I) osteopathic physicians;~~]

[~~(J) social workers;~~]

[~~(K) family counselors;~~]

[~~(L) other health care providers; or~~]

[~~(M) reasonable combinations of the services described in this Subsection (6)(a)(i);~~]

[~~(ii)~~] (i) to an enrollee;

[~~(iii)~~] (ii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished; and

[~~(iv)~~] (iii) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection [~~(6)~~] (3)(a).

(b) "Limited health plan" does not include:

(i) a health maintenance organization;

(ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(iii) an individual who contracts to render professional or personal services that the individual performs.

[~~(7)~~] (4) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.

(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

[~~(8)~~] (5) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:

[~~(b)~~] (a) "organization expenses," which is described in Section 31A-8-208.

[~~(a)~~] (b) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206; or

[~~(9) "Participating provider" means a provider as defined in Subsection (10) who, under a contract with the health maintenance organization, agrees to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.~~]

[~~(10) "Provider" means any person who:~~]

[~~(a) furnishes health care directly to the enrollee; and~~]

[~~(b) is licensed or otherwise authorized to furnish the health care in this state.~~]

[~~(11)~~] (6) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

[~~(12)~~] (7) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.

Section 6. Section **31A-8-103** is amended to read:

31A-8-103. Applicability to other provisions of law.

(1) (a) Except for exemptions specifically granted under this title, an organization is subject to regulation under all of the provisions of this title.

(b) Notwithstanding any provision of this title, an organization licensed under this chapter:

(i) is wholly exempt from:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations;

(B) Chapter 9, Insurance Fraternals;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund;

[~~(F) Chapter 13, Employee Welfare Funds and Plans;~~]

[~~(G)~~] (F) Chapter 19a, Utah Rate Regulation Act; and

[~~(H)~~] (G) Chapter 28, Part 1, Utah Life and Health Insurance Guaranty [~~Associations~~] Association Act; and

(ii) is not subject to:

(A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1, Funding the Insurance Department;

(B) Section 31A-4-107;

(C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for provisions specifically made applicable by this chapter;

(D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by this chapter;

(E) Chapter 17, Determination of Financial Condition, except:

(I) Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

(F) Chapter 18, Investments, except as made applicable by the commissioner by rule consistent with this chapter; and

(G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to [~~health maintenance organizations or~~] limited health plans, upon a finding that the waiver will not endanger the interests of:

(a) enrollees;

(b) investors; or

(c) the public.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,

Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as specifically made applicable by:

(a) this chapter;

(b) a provision referenced under this chapter; or

(c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4) (a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the application is:

(i) of those provisions that apply to a mutual corporation if the organization is nonprofit; and

(ii) of those that apply to a stock corporation if the organization is for profit.

(b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

(7) Except as provided in [~~Section 31A-8-501~~] Chapter 45, Managed Care Organizations, an organization is exempt from statutes in this title or department rules that restrict or limit the organization's freedom of choice in contracting with or selecting health care

providers, including Section 31A-22-618.

(8) An organization is exempt from the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

Section 7. Section **31A-21-106** is amended to read:

31A-21-106. Incorporation by reference.

(1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery, unless the policy, application, or agreement accurately reflects the terms of the incorporated agreement, provision, or attached document.

(b) (i) A policy may by reference incorporate rate schedules and classifications of risks and short-rate tables filed with the commissioner.

(ii) By rule or order, the commissioner may authorize incorporation by reference of provisions for:

(A) administrative arrangements;

(B) premium schedules; and

(C) payment procedures for complex contracts.

(c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional lender may, if requested by an institutional lender, incorporate by reference generally applicable policy terms that are contained in a specifically identified policy that has been filed with the commissioner.

(ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly engages in the business of making loans secured by real estate.

(d) A policy may incorporate by reference the following by citing in the policy:

(i) a federal law or regulation;

(ii) a state law or rule; or

(iii) a public directive of a federal or state agency.

(2) A purported modification of a contract during the term of the policy may not affect

the obligations of a party to the contract:

(a) unless the modification is:

(i) in writing; and

(ii) agreed to by the party against whose interest the modification operates; and

(b) except:

(i) as provided in:

(A) Subsection (3) or (4);

(B) Subsection [~~31A-8-402.3~~] 31A-22-618.6(9); or

[~~(C) Subsection 31A-22-721(10); or~~]

[~~(D)~~] (C) Subsection [~~31A-30-107(8)~~] 31A-22-618.7(4); or

(ii) as otherwise mandated by law.

(3) Subsection (2) does not prevent a change in coverage under group contracts resulting from:

(a) provisions of an employer eligibility rule;

(b) the terms of a collective bargaining agreement; or

(c) provisions in federal Employee Retirement Income Security Act plan documents.

(4) Subsection (2) does not prevent a premium increase at any renewal date that is applicable uniformly to all comparable persons.

Section 8. Section **31A-22-610.1** is amended to read:

31A-22-610.1. Indemnity benefit for adoption or infertility treatments.

(1) (a) (i) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required.

(ii) This section does not prevent an accident and health insurer from:

(A) adjusting the benefit payable under this section for cost sharing measures imposed under the policy or contract for maternity benefit coverage; or

(B) providing additional adoption indemnity benefits including:

(I) extending the period of time after birth in which a child must be placed with an insured; or

(II) providing a benefit in excess of the amount specified in Subsection (1)(c).

(b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:

(i) the postplacement evaluation disapproves the adoption placement; and

(ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

(c) (i) The amount of the adoption indemnity benefit provided under Subsection (1) is $4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).

(ii) An insurer may comply with the provisions of this section by providing the $4,000 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining infertility treatments rather than seeking reimbursement for an adoption in accordance with terms designated by the insurer.

(d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:

(i) has coverage for maternity benefits with a different insurer; and

(ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).

(2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:

(a) a child is placed for adoption with the insured within 90 days of the child's birth; and

(b) the adoption is finalized within one year of the child's birth.

(3) If an insured qualifies for the adoption indemnity benefit under this section and receives services from a [~~health care provider under contract with his insurer, the contracting health care provider~~] network provider, the network provider may only collect from the insured the amount that the contracting health care provider is entitled to receive for such services

under the contract, including any applicable copayment.

[~~(4) For purposes of this section, "contracting health care provider" means:~~]

[~~(a) a "participating provider" as defined in Section 31A-8-101; or~~]

[~~(b) a "preferred health care provider" as described in Section 31A-22-617.~~]

Section 9. Section **31A-22-610.5** is amended to read:

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78B-12-102.

(2) (a) Any individual or group accident and health insurance policy or [~~health maintenance~~] managed care organization contract that provides coverage for a policyholder's or certificate holder's dependent may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.

(d) An individual or group health insurance policy[~~, group health insurance policy, or health maintenance~~] or managed care organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:

(i) if premiums are paid; and

(ii) notwithstanding [~~Section 31A-8-402.3, 31A-8-402.5, 31A-22-721, 31A-30-107.1, or 31A-30-107.3~~] Sections 31A-22-618.6 and 31A-22-618.7.

[~~(3) An individual or group accident and health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations, shall treat the dependent as if the coverage had been in force since it was terminated, if:~~]

[~~(a) the dependent has not reached the age of 26 by July 1, 1995;~~]

[~~(b) the dependent had coverage prior to July 1, 1994;~~]

[~~(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and~~]

[~~(d) the policy has not been terminated since the dependent's coverage was terminated.~~]

[~~(4)~~] (3) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection [~~(5)~~] (4);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; or

(iv) does not reside with the parent or in the insurer's service area.

(b) A child enrolled as required under Subsection [~~(4)~~] (3)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area. [~~A health maintenance organization shall comply with Section 31A-8-502.~~]

[~~(5)~~] (4) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection [~~(5)~~] (4)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection [~~(5)~~] (4)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.

[~~(6)~~] (5) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program; and

(c) (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection [~~(9)~~] (8)(c)(i), (ii), or (iii) has happened.

[~~(7)~~] (6) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

[~~(8)~~] (7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

[~~(9)~~] (8) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

[~~(10)~~] (9) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

[~~(11)~~] (10) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

[~~(12)~~] (11) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

[~~(13)~~] (12) The commissioner shall adopt rules interpreting and implementing this section with regard to out-of-area court ordered dependent coverage.

Section 10. Section **31A-22-613.5** is amended to read:

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

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

(b) Subsection (2) applies to:

(i) all health benefit plans; and

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

(2) [~~(a)~~] The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to[~~: (i)~~] provide to all enrollees, [~~prior to~~] before enrollment in the health benefit plan, written disclosure of:

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

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

[~~(II)~~] (ii) co-payments and deductibles for prescription drugs; and

[~~(III)~~] (iii) requirements for generic substitution;

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

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

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

[~~(II)~~] (ii) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition; and

[~~(D)~~] (d) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits[~~; and~~].

[~~(ii) provide the commissioner with:~~]

[~~(A) the information described in Subsections 31A-22-635(5) through (7) in the standardized electronic format required by Subsection 63N-11-107(1); and~~]

[~~(B) information regarding insurer transparency in accordance with Subsection (4).~~]

[~~(b)~~] (3) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to the commissioner:

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

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

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

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

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

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

[~~(E)~~] (v) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

[~~(c)~~] (4) (a) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a)[~~(i)(A)~~]:

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

[~~(d)~~] (b) If under Subsection (2)(a)[~~(i)(A)~~] a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

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

(ii) Examples of a limitation or exclusion of coverage provided under Subsection

(2)[~~(a)(i)(C)~~](c) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

[~~(3) The commissioner:~~]

[~~(a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to the Health Insurance Exchange created under Section 63N-11-104; and~~]

[~~(b) may request information from an insurer to verify the information submitted by the insurer under this section.~~]

[~~(4) The commissioner shall:~~]

[~~(a) convene a group of insurers, a member representing the Public Employees' Benefit and Insurance Program, consumers, and an organization that provides multipayer and multiprovider quality assurance and data collection, to develop information for consumers to compare health insurers and health benefit plans on the Health Insurance Exchange, which shall include consideration of:~~]

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

[~~(ii) the cost of denied claims that is transferred to providers;~~]

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

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

[~~(v) consumer assessment of each insurer or health benefit plan;~~]

[~~(b) adopt an administrative rule that establishes:~~]

[~~(i) definition of terms;~~]

[~~(ii) the methodology for determining and comparing the insurer transparency information;~~]

[~~(iii) the data, and format of the data, that an insurer shall submit to the commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63N-11-107; and~~]

[~~(iv) the dates on which the insurer shall submit the data to the commissioner in order for the commissioner to transmit the data to the Health Insurance Exchange in accordance with Section 63N-11-107; and~~]

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

Section 11. Section **31A-22-618** is amended to read:

31A-22-618. Nondiscrimination among health care professionals.

[~~(1)~~] Except as provided under Section [~~31A-22-617~~] 31A-45-303 and Subsection [~~(3) of this section~~] (2), and except as to insurers licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, 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.

[~~(2) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.~~]

[~~(3)~~] (2) Coverage for licensed providers for behavioral analysis may be limited by a insurer in accordance with Section 58-61-714. Nothing in this section prohibits an insurer from electing to provide coverage for other licensed professionals whose scope of practice includes behavior analysis.

Section 12. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Coverage of insurance mandates imposed after January 1, 2009.

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

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance

Organizations and Limited Health Plans:

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

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

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

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

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

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

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

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

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

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

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

(a) may offer a health benefit plan that is not subject to Section 31A-22-618 and Subsection 31A-45-303(3)(b)(iii);

(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

(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.

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

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

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

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

Section 13. Section **31A-22-618.6**, which is renumbered from Section 31A-8-402.3 is renumbered and amended to read:

[~~31A-8-402.3~~]. 31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

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

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed [~~for a network plan, if~~]:

(a) for noncompliance with the insurer's employer contribution requirements;

[~~(a)~~] (b) if there is no longer any enrollee under the group health plan who lives, resides, or works in:

(i) the service area of the insurer; or

(ii) the area for which the insurer is authorized to do business; [~~or~~]

[~~(b)~~] (c) for coverage made available in the small or large employer market only

through an association, if:

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

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual[.]; or

(d) for noncompliance with the insurer's minimum employee participation requirements, except as provided in Subsection (3).

(3) If a small employer employs fewer than two eligible employees, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least two current employees.

(4) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average fewer than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

[~~(3)~~] (5) A health benefit plan for a plan sponsor may be discontinued if:

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

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

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

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

(d) the insurer:

(i) elects to discontinue offering a particular health benefit plan product delivered or

issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing[~~: (I)~~] to each plan sponsor, employee, or dependent of a plan sponsor or an employee[~~; and (II)~~], at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing[~~: (I)~~] to the commissioner[~~; and (II)~~], and at least three working days [~~prior to~~] before the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase[~~: (I)~~] all other health benefit plan products currently being offered by the insurer in the market[~~; or (II)~~] or, in the case of a large employer, any other health benefit [~~product~~] plans currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to[~~: (I)~~] the claims experience of a plan sponsor[~~; (II)~~], any health status-related factor relating to any covered participant or beneficiary[~~; or (III)~~], or any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

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

(ii) (A) provides notice of the discontinuation in writing[~~: (I)~~] to each plan sponsor, employee, or dependent of a plan sponsor or an employee[~~; and (II)~~] at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing[~~: (I)~~] to the commissioner in each state in which an affected insured individual is known to reside[~~; and (II)~~] and, at least 30 working days [~~prior to~~] before the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i); and

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

[~~(4) A large employer health benefit plan may be discontinued or nonrenewed:~~]

[~~(a) if a condition described in Subsection (2) exists; or~~]

[~~(b) for noncompliance with the insurer's:~~]

[~~(i) minimum participation requirements; or~~]

[~~(ii) employer contribution requirements.~~]

[~~(5) A small employer health benefit plan may be discontinued or nonrenewed:~~]

[~~(a) if a condition described in Subsection (2) exists; or~~]

[~~(b) for noncompliance with the insurer's employer contribution requirements.~~]

[~~(6) A small employer health benefit plan may be nonrenewed:~~]

[~~(a) if a condition described in Subsection (2) exists; or~~]

[~~(b) for noncompliance with the insurer's minimum participation requirements.~~]

[~~(7)~~] (6) (a) Except as provided in Subsection [~~(7)~~] (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection [~~(7)~~] (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection [~~(7)~~] (6)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection [~~(7)~~] (6) because of a fraud or misrepresentation that relates to health status.

[~~(8)~~] (7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

[~~(9)~~] (8) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 14. Section **31A-22-618.7**, which is renumbered from Section 31A-8-402.5 is renumbered and amended to read:

[~~31A-8-402.5~~]. 31A-22-618.7. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all [~~individuals~~] enrollees or dependents; and

(ii) at the option of the [~~individual~~] enrollee.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) [~~A~~] An individual health benefit plan may be discontinued or nonrenewed:

(a) [~~for a network plan,~~] if:

(i) [~~the individual no longer~~] there is no longer an enrollee under the individual health benefit plan who lives, resides, or works in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered [~~individual~~] enrollee; or

(b) for coverage made available through an association, if:

(i) the [~~individual's~~] enrollee's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered [~~individual~~] enrollee.

(3) [~~A~~] An individual health benefit plan may be discontinued if:

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

(b) the [~~individual~~] enrollee fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the [~~individual~~] enrollee:

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

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

(d) the insurer:

(i) elects to discontinue offering a particular health benefit [~~product~~] plan product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing[~~: (I)~~] to each [~~individual~~] enrollee provided coverage[~~; and (II)~~] at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing[~~: (I)~~] to the commissioner[~~; and (II)~~] and, at least three working days [~~prior to~~] before the date the notice is sent, to the affected [~~individuals~~] enrollees;

(C) offers to each covered [~~individual~~] enrollee on a guaranteed issue basis[~~,~~] the option to purchase all other individual health benefit [~~products~~] plans currently being offered by the insurer for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of covered [~~individuals~~] enrollees or dependents of covered [~~individuals~~] enrollees who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in the individual market; and

(ii) (A) provides notice of the discontinuation in writing[~~: (I)~~] to each [~~individual~~] enrollee provided coverage[~~; and (II)~~] at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing[~~: (I)~~] to the commissioner in each state in which an affected [~~insured individual~~] enrollee is known to reside[~~; and (II)~~] and, at least 30 working days [~~prior to~~] before the date the notice is sent, to the affected [~~individuals~~] enrollees;

(C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of covered [~~individuals~~] enrollees or dependents of covered [~~individuals~~] enrollees who may become eligible for coverage.

(4) An insurer may modify an individual health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all health benefit plans.

Section 15. Section **31A-22-618.8**, which is renumbered from Section 31A-8-402.7 is renumbered and amended to read:

[~~31A-8-402.7~~]. 31A-22-618.8. Discontinuance and nonrenewal limitations.

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health

benefit plan under Subsections [~~31A-8-402.3~~] 31A-22-618.6(3)(e) and [~~31A-8-402.5~~] 31A-22-618.7(3)(e) is prohibited from writing new business:

(a) in the market in this state for which the insurer discontinues or does not renew; and

(b) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(2) If an insurer is doing business in one established geographic service area of the state, Sections [~~31A-8-402.3 and 31A-8-402.5~~] 31A-22-618.6 and 31A-22-618.7 apply only to the insurer's operations in that service area.

(3) The commissioner may, by rule or order, define the scope of service area.

Section 16. Section **31A-22-627** is amended to read:

31A-22-627. Coverage of emergency medical services.

(1) A health insurance policy or [~~health maintenance~~] managed care organization contract:

(a) shall provide, at a minimum, coverage of emergency services as required in 29 C.F.R. Sec. 2590.715-2719A; and

(b) may not:

(i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized; or

(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured.

(2) A health insurance policy or [~~health maintenance~~] managed care organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized. If such authorization is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section:

(a) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention at a hospital emergency department to result in:

(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part[~~; and~~].

(b) "Hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

(c) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

(5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:

(a) work with the insurer to improve the insurer's compliance with this section; or

(b) impose the following fines:

(i) not more than $5,000; or

(ii) twice the amount of any profit gained from violations of this section.

Section 17. Section **31A-22-628** is amended to read:

31A-22-628. Standing referral to a specialist.

(1) With respect to a health insurance policy or [~~health maintenance~~] managed care organization contract that does not allow an insured to have direct access to a health care specialist, the insurer shall establish and implement a procedure by which an insured may

obtain a standing referral to a health care specialist.

(2) The procedure established under Subsection (1):

(a) shall provide for a standing referral to a specialist if the insured's primary care provider determines, in consultation with the specialist, that the insured needs continuing care from the specialist; and

(b) may require the insurer's approval of a treatment plan designed by the specialist, in consultation with the primary care provider and the insured, which may include:

(i) a limit on the number of visits to the specialist;

(ii) a time limit on the duration of the referral; and

(iii) mandatory updates on the insured's condition.

Section 18. Section **31A-22-635** is amended to read:

31A-22-635. Uniform application -- Uniform waiver of coverage.

(1) For purposes of this section, "insurer":

(a) is defined in Subsection 31A-22-634(1); and

(b) includes the state employee's risk pool under Section 49-20-202.

(2) (a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.

(b) The uniform application form:

(i) may not include questions about an applicant's health history; and

(ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.

(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, and is limited to:

(i) information that identifies the employee;

(ii) proof of the employee's insurance coverage; and

(iii) a statement that the employee declines coverage with a particular employer group.

(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[~~: (a) enrollees using the Health Insurance Exchange; or (b)~~] insurers using electronic applications.

(4) (a) 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.

[~~(5) (a) An insurer who offers a health benefit plan on the Health Insurance Exchange created in Section 63N-11-104, shall:~~]

[~~(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 63N-11-107;~~]

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

[~~(iii) post all health benefit plans offered by the insurer in the defined contribution arrangement market on the Health Insurance Exchange; and~~]

[~~(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.~~]

[~~(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.~~]

[~~(c) Notwithstanding Subsection (5)(b):~~]

[~~(i) an insurer may offer a health savings account on the Health Insurance Exchange;~~]

[~~(ii) an insurer may offer dental plans on the Health Insurance Exchange; and~~]

[~~(iii) the department may make administrative rules to regulate the offer of dental plans on the Health Insurance Exchange.~~]

[~~(6) An insurer shall provide the commissioner and the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance~~

~~Exchange, in the electronic format required by Subsection 63N-11-107(1).~~]

[~~(a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;~~]

[~~(b) information and Internet address to online provider networks;~~]

[~~(c) wellness programs and incentives;~~]

[~~(d) descriptions of prescription drug benefits, exclusions, or limitations;~~]

[~~(e) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and~~]

[~~(f) the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(4).~~]

[~~(7) The department shall post on the Health Insurance Exchange the department's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each insurer shall be based on methodology established by the department by administrative rule and shall be updated each calendar year.~~]

[~~(8) (a) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance Exchange.~~]

(b) The commissioner shall regulate the fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Section 19. Section **31A-22-642** is amended to read:

31A-22-642. Insurance coverage for autism spectrum disorder.

(1) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism spectrum disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders

(DSM).

(c) "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

(i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(ii) provided or supervised by a:

(A) board certified behavior analyst; or

(B) person licensed under Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, whose scope of practice includes mental health services.

(d) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests:

(i) performed by a licensed physician who is board certified in neurology, psychiatry, or pediatrics and has experience diagnosing autism spectrum disorder, or a licensed psychologist with experience diagnosing autism spectrum disorder; and

(ii) necessary to diagnose whether an individual has an autism spectrum disorder.

(e) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(f) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(g) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(h) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.

(i) "Treatment for autism spectrum disorder":

(i) means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a physician or a licensed psychologist described in Subsection (1)(d) who determines the care to be medically necessary;

and

(ii) includes:

(A) behavioral health treatment, provided or supervised by a person described in Subsection (1)(c)(ii);

(B) pharmacy care;

(C) psychiatric care;

(D) psychological care; and

(E) therapeutic care.

(2) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2016, shall provide coverage for the diagnosis and treatment of autism spectrum disorder:

(a) for a child who is at least two years old, but younger than 10 years old; and

(b) in accordance with the requirements of this section and rules made by the commissioner.

(3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to set the minimum standards of coverage for the treatment of autism spectrum disorder.

(4) Subject to Subsection (5), the rules described in Subsection (3) shall establish durational limits, amount limits, deductibles, copayments, and coinsurance for the treatment of autism spectrum disorder that are similar to, or identical to, the coverage provided for other illnesses or diseases.

(5) (a) Coverage for behavioral health treatment for a person with an autism spectrum disorder shall cover at least 600 hours a year. Other terms and conditions in the health benefit plan that apply to other benefits covered by the health benefit plan apply to coverage required by this section.

(b) Notwithstanding [~~Subsection 31A-22-617(6)~~] Section 31A-45-303, a health benefit plan providing treatment under Subsection (5)(a) shall include in the plan's provider network

both board certified behavior analysts and mental health providers qualified under Subsection (1)(c)(ii).

(6) A health care provider shall submit a treatment plan for autism spectrum disorder to the insurer within 14 business days of starting treatment for an individual. If an individual is receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once every six months. A review of treatment under this Subsection (6) may include a review of treatment goals and progress toward the treatment goals. If an insurer makes a determination to stop treatment as a result of the review of the treatment plan under this subsection, the determination of the insurer may be reviewed under Section 31A-22-629.

(7) (a) In accordance with Subsection (7)(b), the commissioner shall waive the requirements of this section for all insurers in the individual market or the large group market, if an insurer demonstrates to the commissioner that the insurer's entire pool of business in the individual market or the large group market has incurred claims for the autism coverage required by this section in a 12 consecutive month period that will cause a premium increase for the insurer's entire pool of business in the individual market or the large group market in excess of 1% over the insurer's premiums in the previous 12 consecutive month period.

(b) The commissioner shall waive the requirements of this section if:

(i) after a public hearing in accordance with Title 63G, Chapter 4, Administrative Procedures Act, the commissioner finds that the insurer has demonstrated to the commissioner based on generally accepted actuarial principles and methodologies that the insurer's entire pool of business in the individual market or the large group market will experience a premium increase of 1% or greater as a result of the claims for autism services as described in this section; or

(ii) the attorney general issues a legal opinion that the limits under Subsection (5)(a) cannot be implemented by an insurer in a manner that complies with federal law.

(8) If a waiver is granted under Subsection (7), the insurer may:

(a) continue to offer autism coverage under the existing plan until the next renewal

period for the plan, at which time the insurer:

(i) may delete the autism coverage from the plan without having to re-apply for the waiver under Subsection (7); and

(ii) file the plan with the commissioner in accordance with guidelines issued by the commissioner;

(b) discontinue offering plans subject to Subsection (2), no earlier than the next calendar quarter following the date the waiver is granted, subject to filing guidelines issued by the commissioner; or

(c) nonrenew existing plans that are subject to Subsection (2), in compliance with Subsection [~~31A-30-107(3)(d)~~] 31A-22-618.6(5) or Subsection 31A-22-618.7(3).

(9) This section sunsets in accordance with Section 63I-1-231.

Section 20. Section **31A-23a-402** is amended to read:

31A-23a-402. Unfair marketing practices -- Communication -- Unfair discrimination -- Coercion or intimidation -- Restriction on choice.

(1) (a) (i) Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance product or contract, any insurer, or any licensee under this title, including information that is false or misleading because it is incomplete:

(A) a person who is or should be licensed under this title;

(B) an employee or producer of a person described in Subsection (1)(a)(i)(A);

(C) a person whose primary interest is as a competitor of a person licensed under this title; and

(D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

(ii) As used in this Subsection (1), "false or misleading information" includes:

(A) assuring the nonobligatory payment of future dividends or refunds of unused premiums in any specific or approximate amounts, but reporting fully and accurately past experience is not false or misleading information; and

(B) with intent to deceive a person examining it:

(I) filing a report;

(II) making a false entry in a record; or

(III) wilfully refraining from making a proper entry in a record.

(iii) A licensee under this title may not:

(A) use any business name, slogan, emblem, or related device that is misleading or likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee already in business; or

(B) use any name, advertisement, or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency, including [~~the Health Insurance Exchange, also called the "Utah Health Exchange" or~~] Utah's small employer health insurance exchange known as "Avenue H," [~~created in Section 63N-11-104, the Comprehensive Health Insurance Pool created in Chapter 29, Comprehensive Health Insurance Pool Act,~~] and the Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act:

(I) is responsible for the insurance sales activities of the person;

(II) stands behind the credit of the person;

(III) guarantees any returns on insurance products of or sold by the person; or

(IV) is a source of payment of any insurance obligation of or sold by the person.

(iv) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that person is an insurer.

(v) A person other than persons licensed as health maintenance organizations under Chapter 8, Health Maintenance Organizations and Limited Health Plans, may not use the term "Health Maintenance Organization" or "HMO" in referring to itself.

(b) A licensee's violation creates a rebuttable presumption that the violation was also committed by the insurer if:

(i) the licensee under this title distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1)(a), with reference to a particular insurer:

(A) that the licensee represents; or

(B) for whom the licensee processes claims; and

(ii) the cards, documents, signs, or advertisements are supplied or approved by that insurer.

(2) (a) A title insurer, individual title insurance producer, or agency title insurance producer or any officer or employee of the title insurer, individual title insurance producer, or agency title insurance producer may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business:

(i) any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the title insurance;

(ii) any special favor or advantage not generally available to others;

(iii) any money or other consideration, except if approved under Section 31A-2-405; or

(iv) material inducement.

(b) "Charge made incident to the issuance of the title insurance" includes escrow charges, and any other services that are prescribed in rule by the Title and Escrow Commission after consultation with the commissioner and subject to Section 31A-2-404.

(c) An insured or any other person connected, directly or indirectly, with the transaction may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(a), including:

(i) a person licensed under Title 61, Chapter 2c, Utah Residential Mortgage Practices and Licensing Act;

(ii) a person licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act;

(iii) a builder;

(iv) an attorney; or

(v) an officer, employee, or agent of a person listed in this Subsection (2)(c)(iii).

(3) (a) An insurer may not unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage, except on the basis of

classifications related to the nature and the degree of the risk covered or the expenses involved.

(b) Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly discriminatory merely because they are more favorable than in similar individual policies.

(4) (a) This Subsection (4) applies to:

(i) a person who is or should be licensed under this title;

(ii) an employee of that licensee or person who should be licensed;

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) one acting on behalf of any person described in Subsections (4)(a)(i) through (iii).

(b) A person described in Subsection (4)(a) may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that:

(i) tends to produce:

(A) an unreasonable restraint of the business of insurance; or

(B) a monopoly in that business; or

(ii) results in an applicant purchasing or replacing an insurance contract.

(5) (a) (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an insurer or licensee under this chapter, another person who is required to pay for insurance as a condition for the conclusion of a contract or other transaction or for the exercise of any right under a contract.

(ii) A person requiring coverage may reserve the right to disapprove the insurer or the coverage selected on reasonable grounds.

(b) The form of corporate organization of an insurer authorized to do business in this state is not a reasonable ground for disapproval, and the commissioner may by rule specify additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an application for insurance.

(6) A person may not make any charge other than insurance premiums and premium

financing charges for the protection of property or of a security interest in property, as a condition for obtaining, renewing, or continuing the financing of a purchase of the property or the lending of money on the security of an interest in the property.

(7) (a) A licensee under this title may not refuse or fail to return promptly all indicia of agency to the principal on demand.

(b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308, 31A-23a-111, or 31A-23a-112 may not refuse or fail to return the license to the commissioner on demand.

(8) (a) A person may not engage in an unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that the method of competition, the act, or the practice:

(i) is misleading;

(ii) is deceptive;

(iii) is unfairly discriminatory;

(iv) provides an unfair inducement; or

(v) unreasonably restrains competition.

(b) Notwithstanding Subsection (8)(a), for purpose of the title insurance industry, the Title and Escrow Commission shall make rules, subject to Section 31A-2-404, that define an unfair method of competition or unfair or deceptive act or practice after a finding that the method of competition, the act, or the practice:

(i) is misleading;

(ii) is deceptive;

(iii) is unfairly discriminatory;

(iv) provides an unfair inducement; or

(v) unreasonably restrains competition.

Section 21. Section **31A-30-102** is amended to read:

31A-30-102. Purpose statement.

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

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

(b) renewability of coverage;

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

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

[~~(6) provide an employer with the opportunity to establish a defined contribution arrangement for an employee to purchase a health benefit plan through the Health Insurance Exchange created by Section 63N-11-104.~~]

Section 22. Section **31A-30-104** is amended to read:

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers, except as provided in Subsection (3); or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association, except as provided in Subsection (3);

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) short-term limited duration health insurance;

(b) federally funded or partially funded programs; or

(c) a bona fide employer association.

(4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner [~~or by Chapter 42, Defined Contribution Risk Adjuster Act~~], a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if the ceding arrangements would result in less than 50% of the insurance obligation or risk for the health benefit plans being retained by the ceding carrier.

(d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

(5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsections 31A-30-106(1) and 31A-30-106.1(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a

waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection (5) may not apply to an individual if the person participates in a Taft Hartley trust as an associate member of any employee organization.

(6) Sections 31A-22-618.6, 31A-30-106, 31A-30-106.1, 31A-30-106.5, 31A-30-106.7, [~~31A-30-107~~,] and 31A-30-108, apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the small employer's employees provided as an employee benefit.

(7) The commissioner may make rules requiring that the marketing practices be consistent with this chapter for:

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer;

(d) an insurance consultant; and

(e) a navigator.

Section 23. Section **31A-30-106.7** is amended to read:

31A-30-106.7. Surcharge for groups changing carriers.

(1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could

otherwise charge under Section 31A-30-106.1.

(b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

(i) the change in carriers occurs on the anniversary of the plan year, as defined in Section 31A-1-301;

(ii) the previous coverage was terminated under Subsection [~~31A-30-107(3)(c)~~] 31A-22-618.6(5);

(iii) employees from an existing group form a new business; and

(iv) the surcharge is not applied uniformly to all similarly situated small groups.

(2) A covered carrier may not impose the surcharge described in Subsection (1) if the offer to cover the group occurs at a time other than the anniversary of the plan year because:

(a) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) the offer to cover the group is not issued until after the anniversary date; or

(b) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) additional underwriting or rating information requested by the covered carrier is not received until after the anniversary date.

(3) If a covered carrier chooses to apply a surcharge under Subsection (1), the application of the surcharge and the criteria for incurring or avoiding the surcharge shall be clearly stated in the:

(a) written application materials provided to the applicant at the time of application; and

(b) written producer guidelines.

(4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to ensure compliance with this section.

Section 24. Section **31A-30-204** is amended to read:

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

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

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

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

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

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

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

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

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

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

(2) (a) (i) An employer that chooses to participate in a defined contribution arrangement health benefit plan may not offer to an employee a health benefit plan that is not a defined contribution arrangement health benefit plan in the Health Insurance Exchange.

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

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

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

health benefit plan; and

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

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

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

(a) establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the [~~Health Insurance Exchange created in Section 63N-11-104~~] small employer health insurance exchange known as Avenue H, which may include:

(i) a health reimbursement arrangement;

(ii) a Section 125 Cafeteria plan; or

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

(b) before the employee's health benefit plan selection period:

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

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

(iii) notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, before the employee's selection period ends:

(A) selects a different defined contribution arrangement health benefit plan available in the Health Insurance Exchange;

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

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

(4) An employer shall enroll an employee in the default defined contribution

arrangement health benefit plan selected by the employer if the employee does not make one of the choices described in Subsection (3)(b)(iii) before the end of the employee selection period, which may not be less than 14 calendar days.

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

Section 25. Section **31A-34-110** is amended to read:

31A-34-110. Contracts with member employers and contracted insurers.

(1) Contracts between an alliance and members shall provide that the alliance is the contract holder of the health benefit plan policy on behalf of members and enrollees.

(2) Contracts between an alliance and a contracted insurer shall specify how premiums will be transferred, what penalties and grace periods will be, and how examination costs will be allocated to contracted insurers.

[~~(3) Subject only to Sections 31A-8-105.5 and 31A-8-501, and until July 1, 2004, health benefit plans offered exclusively in an alliance under this chapter may limit reimbursement to providers on the panel of a contracted insurer if the commissioner finds that the aggregate of alliance contracts available to its members provide a broad and substantial choice of providers, encompassing the vast majority of doctors and hospitals in the state.~~]

Section 26. Section **31A-45-101** is enacted to read:

CHAPTER 45. MANAGED CARE ORGANIZATIONS

Part 1. General Provisions

31A-45-101. Title.

This chapter is known as "Managed Care Organizations."

Section 27. Section **31A-45-102** is enacted to read:

31A-45-102. Definitions.

As used in this chapter:

(1) "Covered benefit" or "benefit" means the health care services to which a covered

person is entitled under the terms of a health benefit plan.

(2) "Managed care organization" means:

(a) a managed care organization as that term is defined in Section 31A-1-103; and

(b) a third party administrator as that term is defined in Section 31A-1-103.

Section 28. Section **31A-45-103** is enacted to read:

31A-45-103. Managed care contract standards.

The commissioner shall adopt rules relating to standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this chapter, dealing with at least the following matters:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage provisions;

(4) coverage of dependents;

(5) termination of insurance;

(6) limitations;

(7) exceptions;

(8) reductions;

(9) definition of terms; and

(10) rating practices.

Section 29. Section **31A-45-201** is enacted to read:

Part 2. Applicability to Other Provisions of Law

31A-45-201. Applicability to other provisions of law -- Commissioner discretion.

(1) Except for exemptions specifically granted under this title, a managed care organization is subject to regulation under all of the provisions of this title.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to managed care organizations, upon a finding that the waiver will not endanger the interests of:

(a) enrollees;

(b) investors;

(c) the public; or

(d) health care providers.

Section 30. Section **31A-45-301** is enacted to read:

Part 3. Relationships with Providers

31A-45-301. Written contracts -- Limited liability of enrollee -- Provider claim disputes -- Leased networks.

(1) A managed care organization may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment. Every contract between a managed care organization and a network provider shall be in writing and shall set forth that if the managed care organization:

(a) fails to pay for health care services as set forth in the contract, the enrollee is not liable to the health care provider for any sums owed by the managed care organization; and

(b) becomes insolvent, the rehabilitator or liquidator may require the network provider to:

(i) continue to provide health care services under the contract between the network provider and the managed care organization until the earlier of:

(A) 90 days after the date of the filing of a petition for rehabilitation or a petition for liquidation; or

(B) the date the term of the contract ends; and

(ii) subject to Subsection (3), reduce the fees the network provider is otherwise entitled to receive from the managed care organization under the contract between the network provider and the managed care organization during the time period described in Subsection (1)(b)(i).

(2) If the conditions of Subsection (3) are met, the network provider:

(a) shall accept the reduced payment as payment in full; and

(b) as provided in Subsection (1)(a), may not collect additional amounts from the insolvent managed care organization's enrollee, except as may be owed under Subsection (3)(b).

(3) Notwithstanding Subsection (1)(b)(ii):

(a) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the network provider contract; and

(b) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the network provider that the enrollee was required to pay before the filing of:

(i) the petition for rehabilitation; or

(ii) the petition for liquidation.

(4) A network provider may not collect or attempt to collect from the enrollee sums owed by the managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(b)(ii) if the network provider contract:

(a) is not in writing as required in Subsection (1); or

(b) fails to contain the language required by Subsection (1).

(5) (a) A person listed in Subsection (5)(b) may not bill or maintain any action at law against an enrollee to collect:

(i) sums owed by the organization; or

(ii) the amount of the regular fee reduction authorized under Subsection (1)(b)(ii).

(b) Subsection (5)(a) applies to:

(i) a network provider;

(ii) an agent;

(iii) a trustee; or

(iv) an assignee of a person described in Subsections (5)(b)(i) through (iii).

(c) In any dispute involving a network provider's claim for reimbursement, the network provider's claim shall be determined in accordance with applicable law, the network provider contract, the enrollee contract, and the managed care organization's written payment policies in effect at the time services were rendered.

(d) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party shall bear its own expense except

that the cost of the jointly selected arbitrator shall be equally shared. This Subsection (5)(d) does not apply to the claim of a general acute hospital to the extent the claim is inconsistent with the hospital's provider agreement.

(e) A managed care organization may not penalize a network provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(6) If a managed care organization permits another private entity with which the managed care organization does not share common ownership or control to use or otherwise lease one or more of the organization's networks that include network providers, the managed care organization shall ensure, at a minimum, that the entity pays the network providers included in the managed care organization's network in accordance with the same fee schedule and general payment policies as the managed care organization would pay for those network providers, unless payment for services is governed by a public program's fee schedule.

Section 31. Section **31A-45-302** is enacted to read:

31A-45-302. Provider payment information -- Notice of admissions.

(1) (a) A managed care organization shall provide the managed care organization's network providers access to current information necessary for the network provider to determine:

(i) the effect of procedure codes on payment or compensation before a claim is submitted for a procedure;

(ii) the plans and carrier networks that the network provider is subject to as part of the contract with the managed care organization; and

(iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms under which the network provider will be paid for health care services.

(b) The information required by Subsection (1)(a) may be provided through a website, and if requested by the network provider, notice of the updated website shall be provided by the managed care organization.

(2) (a) A managed care organization may not require a health care provider by contract, reimbursement procedure, or otherwise to notify the managed care organization of a hospital

inpatient emergency admission within a period of time that is less than one business day of the hospital inpatient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.

(b) Subsection (2)(a) does not prohibit the applicability or administration of other contract provisions between a managed care organization and a network provider that require preauthorization for scheduled inpatient admissions.

Section 32. Section **31A-45-303**, which is renumbered from Section 31A-22-617 is renumbered and amended to read:

[~~31A-22-617~~]. 31A-45-303. Network provider contract provisions.

[~~Health insurance policies~~]

(1) Managed care organizations may provide for [~~insureds~~] enrollees to receive services or reimbursement under the [~~policies~~] health benefit plans in accordance with [~~preferred health care provider contracts as follows:~~] this section.

[~~(1)~~] (2) (a) Subject to restrictions under this section, [~~an insurer or third party administrator~~] a managed care organization may enter into contracts with health care providers [~~as defined in Section 78B-3-403~~] under which the health care providers agree to be a network provider and supply services, at prices specified in the contracts, to [~~persons insured by an insurer~~] enrollees.

[~~(a) (i) A health care~~] (b) A network provider contract [~~may~~] shall require the [~~health care~~] network provider to accept the specified payment in this Subsection [~~(1)~~] (2) as payment in full, relinquishing the right to collect [~~additional~~] amounts other than copayments, coinsurance, and deductibles from the [~~insured person~~] enrollee.

[~~(ii) In a 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.~~]

[~~(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.~~]

[~~(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.~~]

[~~(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.~~]

[~~(b)~~] (c) The insurance contract may reward the [~~insured~~] enrollee for selection of [~~preferred health care~~] network providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

[~~(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):~~]

[~~(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:~~]

[~~(A) require the health care provider to continue to provide health care services under the contract until the earlier of:~~]

[~~(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or~~]

[~~(II) the date the term of the contract ends; and~~]

[~~(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);~~]

[~~(ii) the provider is required to:~~]

[~~(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and~~]

[~~(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);~~]

[~~(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 requirements described in Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:~~]

[~~(A) sums owed by the insolvent managed care organization; or~~]

[~~(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);~~]

[~~(iv) the following may not bill or maintain an 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):~~]

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

[~~(B) an agent;~~]

[~~(C) a trustee; or~~]

[~~(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and~~]

[~~(v) notwithstanding Subsection (1)(c)(i):~~]

[~~(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~~]

[~~(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:~~]

[~~(I) a petition for rehabilitation; or~~]

[~~(II) a petition for liquidation.~~]

[~~(2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014.~~]

[~~(b)~~] (3) (a) When reimbursing for services of health care providers [~~not under contract, the insurer may~~] that are not network providers, the managed care organization may:

(i) make direct payment to the [~~insured.~~] enrollee; and

[~~(c) An insurer using preferred health care provider contracts may~~]

(ii) impose a deductible on coverage of health care providers not under contract.

(b) (i) Subsections (3)(b)(iii) and (c) apply to a managed care organization licensed under:

(A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(B) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(C) Chapter 14, Foreign Insurers; and

(ii) Subsections (3)(b)(iii) and (c) and Subsection (6)(b) do not apply to a managed care organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans.

[~~(d)~~] (iii) When selecting health care providers with whom to contract under Subsection [~~(1), an insurer~~] (2), a managed care organization described in Subsection (3)(b)(i) may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection [~~(7)~~] (6).

[~~(c)~~] (c) For purposes of this section, unfair discrimination between classes of health care providers includes:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly used by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the [~~insurer~~] managed care organization; and

(C) within the scope of practice of the class of health care providers.

[~~(3)~~] (4) Before the [~~insured~~] enrollee consents to the insurance contract, the [~~insurer~~] managed care organization shall fully disclose to the [~~insured that it~~] enrollee that the managed

care organization has entered into [~~preferred health care~~] network provider contracts. The [~~insurer~~] managed care organization shall provide sufficient detail on the [~~preferred health care~~] network provider contracts to permit the [~~insured~~] enrollee to agree to the terms of the insurance contract. The [~~insurer~~] managed care organization shall provide at least the following information:

(a) a list of the health care providers under contract, and if requested their business locations and specialties;

(b) a description of the insured benefits, including deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection [~~(4)~~] (5); and

(d) a description of the adverse benefit determination procedures required under [~~Subsection (5)~~] Section 31A-22-629.

[~~(4) (a) An insurer using preferred health care~~]

(5) (a) A managed care organization using network provider contracts shall maintain a quality assurance program for assuring that the care provided by the [~~health care providers under contract~~] network providers meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the managed care organization and [~~its~~] the managed care organization's health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

[~~(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.~~]

[~~(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.~~]

[~~(7)~~] (6) (a) A health care provider or [~~insurer~~] managed care organization may not discriminate against a [~~preferred health care~~] network provider for agreeing to a contract under Subsection [~~(1)~~] (2).

(b) (i) Subsections (6)(b) and (c) apply to a managed care organization that is described in Subsection (3)(b)(i) and do not apply to a managed care organization described in Subsection (3)(b)(ii).

(ii) A health care provider licensed to treat an illness or injury within the scope of the health care provider's practice, [~~who~~] that is willing and able to meet the terms and conditions established by the [~~insurer~~] managed care organization for designation as a [~~preferred health care~~] network provider, shall be able to apply for and receive the designation as a [~~preferred health care~~] network provider. Contract terms and conditions may include reasonable limitations on the number of designated [~~preferred health care~~] network providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

[~~(8)~~] (c) Upon the written request of a provider excluded from a network provider contract, the commissioner may hold a hearing to determine if the [~~insurer's~~] managed care organization's exclusion of the provider is based on the criteria set forth in Subsection [~~(7)~~] (6)(b).

[~~(9)~~] (7) Nothing in this section is to be construed as to require [~~an insurer~~] a managed care organization to offer a certain benefit or service as part of a health benefit plan.

[~~(10) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.~~]

[~~(11)~~] (8) Notwithstanding Subsection [~~(1),~~] (2) or Subsection [~~(7)~~] (6)(b), [~~and Section~~

~~31A-22-618, an insurer~~] a managed care organization described in Subsection (3)(b)(i) or third party administrator is not required to, but may, enter into a contract with a licensed athletic trainer, licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

Section 33. Section **31A-45-304**, which is renumbered from Section 31A-22-617.1 is renumbered and amended to read:

[~~31A-22-617.1~~]. 31A-45-304. Objective criteria for adding or terminating network providers -- Termination of contracts -- Review process.

(1) (a) [~~Every insurer, including a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans,~~] A managed care organization shall establish criteria for adding health care providers to a new or existing network provider panel.

(b) Criteria under Subsection (1)(a) may include[~~, but are not limited to~~]:

(i) training, certification, and hospital privileges;

(ii) number of [~~physicians~~] health care providers needed to adequately serve the [~~insurer's~~] managed care organization's population; and

(iii) any other factor that is reasonably related to promote or protect good patient care, address costs, take into account on-call and cross-coverage relationships between providers, or serve the lawful interests of the [~~insurer~~] managed care organization.

(c) [~~An insurer~~] A managed care organization shall make such criteria available to any provider upon request and shall file the same with the department.

(d) Upon receipt of a provider application and upon receiving all necessary information, [~~an insurer~~] a managed care organization shall make a decision on a provider's application for participation within 120 days.

(e) If the provider applicant is rejected, the [~~insurer~~] managed care organization shall inform the provider of the reason for the rejection relative to the criteria established in accordance with Subsection (1)(b).

(f) [~~An insurer~~] A managed care organization may not reject a provider applicant based solely on:

(i) the provider's staff privileges at a general acute care hospital not under contract with the [~~insurer~~] managed care organization; or

(ii) the provider's referral patterns for patients who are not covered by the [~~insurer~~] managed care organization.

(g) Criteria set out in Subsection (1)(b) may be modified or changed from time to time to meet the business needs of the market in which the [~~insurer~~] managed care organization operates and, if modified, will be filed with the department as provided in Subsection (1)(c).

(h) With the exception of Subsection (1)(f), this section does not create any new or additional private right of action for redress.

(2) (a) For the first two years, [~~an insurer~~] a managed care organization may terminate its contract with a provider with or without cause upon giving the requisite amount of notice provided in the agreement, but in no case shall it be less than 60 days.

(b) An agreement may be terminated for cause as provided in the contract established between the [~~insurer~~] managed care organization and the provider. Such contract shall contain sufficiently certain criteria so that the provider can be reasonably informed of the grounds for termination for cause.

(c) [~~Prior to~~] Before termination for cause, the [~~insurer shall~~] managed care organization:

(i) shall inform the provider of the intent to terminate and the grounds for doing so;

(ii) shall at the request of the provider, meet with the provider to discuss the reasons for termination;

(iii) if the [~~insurer~~] managed care organization has a reasonable basis to believe that the provider may correct the conduct giving rise to the notice of termination, [~~the insurer~~] may, at its discretion, place the provider on probation with corrective action requirements, restrictions, or both, as necessary to protect patient care; and

(iv) if the [~~insurer~~] managed care organization has a reasonable basis to believe that the provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, [~~the insurer~~] may immediately suspend the provider from further performance under the

contract, provided that the remaining provisions of this Subsection (2) are followed in a timely manner before termination may become final.

(d) Each [~~insurer~~] managed care organization shall establish an internal appeal process for actions that may result in terminated participation with cause and make known to the provider the procedure for appealing such termination.

(i) Providers dissatisfied with the results of the appeal process may, if both parties agree, submit the matters in dispute to mediation.

(ii) If the matters in dispute are not mediated, or should mediation be unsuccessful, the dispute shall be subject to binding arbitration by an arbitrator jointly selected by the parties, the cost of which shall be jointly shared. Each party shall bear its own additional expenses.

(e) A termination under Subsection (2)(a) or (b) may not be based on:

(i) the provider's staff privileges at a general acute care hospital not under contract with the [~~insurer~~] managed care organization; or

(ii) the provider's referral patterns for patients who are not covered by the [~~insurer~~] managed care organization.

(3) Notwithstanding any other section of this title, [~~an insurer~~] a managed care organization may not take adverse action against or reduce reimbursement to a [~~contracted~~] network provider who is not under a capitated reimbursement arrangement because of the decision of an [~~insured~~] enrollee to access health care services from a [~~noncontracted~~] non-network provider in a manner permitted by the [~~insured's~~] enrollee's health insurance plan, regardless of how the plan is designated.

Section 34. Section **31A-45-401**, which is renumbered from Section 31A-8-502 is renumbered and amended to read:

Part 4. Access To Services For Managed Care Enrollees

[~~31A-8-502~~]. 31A-45-401. Court ordered coverage for minor children who reside outside the service area.

(1) (a) The requirements of Subsection (2) apply to a [~~health maintenance organization if the health maintenance organization plan~~] managed care organization if the managed care

organization health benefit plan:

(i) restricts coverage for nonemergency services to services provided by contracted providers within the organization's service area; and

(ii) does not offer a benefit that permits members the option of obtaining covered services from a [~~non-contracted~~] non-network provider.

(b) The requirements of Subsection (2) do not apply to a [~~health maintenance~~] managed care organization if:

(i) the child that is the subject of a court or administrative support order is over the age of 18 and is no longer enrolled in high school; or

(ii) a parent's employer offers the parent a choice to select health insurance coverage that is not a [~~health maintenance~~] managed care organization plan either at the time of the court or administrative support order, or at a subsequent open enrollment period. This exemption from Subsection (2) applies even if the parent ultimately chooses the [~~health maintenance~~] managed care organization plan.

(2) If a parent is required by a court or administrative support order to provide health insurance coverage for a child who resides outside of a [~~health maintenance~~] managed care organization's service area, the [~~health maintenance~~] managed care organization shall:

(a) comply with the provisions of Section 31A-22-610.5;

(b) allow the enrollee parent to enroll the child on the organization plan;

(c) pay for otherwise covered health care services rendered to the child outside of the service area by a [~~noncontracted~~] non-network provider:

(i) if the child, noncustodial parent, or custodial parent has complied with prior authorization or utilization review otherwise required by the organization; and

(ii) in an amount equal to the dollar amount the organization pays under a noncapitated arrangement for comparable services to a [~~contracting~~] network provider in the same class of health care providers as the provider who rendered the services; and

(d) make payments on claims submitted in accordance with Subsection (2)(c) directly to the provider, custodial parent, the child who obtained benefits, or state Medicaid agency.

(3) (a) The parents of the child who is the subject of the court or administrative support order are responsible for any charges billed by the provider in excess of those paid by the organization.

(b) This section does not affect any court or administrative order regarding the responsibilities between the parents to pay any medical expenses not covered by accident and health insurance or a [~~health maintenance~~] managed care organization plan.

(4) The commissioner shall adopt rules as necessary to administer this section and Section 31A-22-610.5.

Section 35. Section **31A-45-402** is enacted to read:

31A-45-402. Alcohol and drug dependency treatment.

(1) A managed care organization offering a health benefit plan providing coverage for alcohol or drug dependency treatment may require an inpatient facility to be licensed by:

(a) (i) the Department of Human Services, under Title 62A, Chapter 2, Licensure of Programs and Facilities; or

(ii) the Department of Health; or

(b) for an inpatient facility located outside the state, a state agency similar to one described in Subsection (1)(a).

(2) For inpatient coverage provided pursuant to Subsection (1), a managed care organization may require an inpatient facility to be accredited by the following:

(a) the Joint Commission; and

(b) one other nationally recognized accrediting agency.

Section 36. Section **31A-45-501**, which is renumbered from Section 31A-8-501 is renumbered and amended to read:

Part 5. Network Adequacy

[~~31A-8-501~~]. 31A-45-501. Access to health care providers.

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification

category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

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

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

(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.

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

(i) is either:

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

(B) licensed as of January 1, 2004;

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

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

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

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

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member [~~who~~] that has not contracted with a [~~health maintenance~~] managed care organization to provide health care services to enrollees of the managed care

organization.

(2) Except for a [~~health maintenance~~] managed care organization [~~which~~] that is under the common ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a [~~health maintenance~~] managed care organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

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

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

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

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the [~~health maintenance~~] managed care organization contract.

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

(a) the enrollee:

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

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

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

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the [~~health maintenance~~] managed care organization

contract.

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

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

(5) (a) A noncontracting independent hospital may not balance bill a patient when the health maintenance organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a).

(b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

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

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

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

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

(ii) is within 30 paved road miles of:

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

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

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

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

(b) Violations of this section include:

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

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

(A) an enrollee makes personal contact with the [~~health maintenance~~] managed care organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about [~~his~~] the enrollee's rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the [~~health maintenance~~] managed care organization, when the provisions of this section apply to the claim.

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

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

(ii) identify in rule:

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

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

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

(d) (i) A [~~health maintenance~~] managed care organization shall:

(A) use the information developed by the commissioner under Subsection (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are

located in the [~~health maintenance~~] managed care organization's service area; and

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

(ii) The [~~health maintenance~~] managed care organization shall provide the following notice, in bold type, to enrollees as specified under Subsection (8)(b)(i), and shall keep the notice current:

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

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

If you have questions concerning your rights to see a provider on this list you may contact your [~~health maintenance~~] managed care organization at _____. If the [~~HMO~~] managed care organization does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

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

Section 37. Section **49-20-407** is amended to read:

49-20-407. Insurance mandates.

Notwithstanding the provisions of Subsection 31A-1-103(3)(f):

(1) health coverage offered to the state employee risk pool under Subsection 49-20-202(1)(a) shall comply with the provisions of Sections [~~31A-8-501 and~~] 31A-22-605.5 and 31A-45-501; and

(2) a health plan offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b) shall comply with the provisions of Section

31A-22-605.5.

Section 38. Section **53-2a-1102** is amended to read:

53-2a-1102. Search and Rescue Financial Assistance Program -- Uses -- Rulemaking -- Distribution.

(1) (a) "Assistance card program" means the Utah Search and Rescue Assistance Card Program created within this section.

(b) "Card" means the Search and Rescue Assistance Card issued under this section to a participant.

(c) "Participant" means an individual, family, or group who is registered pursuant to this section as having a valid card at the time search, rescue, or both are provided.

(d) "Program" means the Search and Rescue Financial Assistance Program created within this section.

(e) (i) "Reimbursable expenses," as used in this section, means those reasonable expenses incidental to search and rescue activities.

(ii) "Reimbursable expenses" include:

(A) rental for fixed wing aircraft, helicopters, snowmobiles, boats, and generators;

(B) replacement and upgrade of search and rescue equipment;

(C) training of search and rescue volunteers;

(D) costs of providing workers' compensation benefits for volunteer search and rescue team members under Section 67-20-7.5; and

(E) any other equipment or expenses necessary or appropriate for conducting search and rescue activities.

(iii) "Reimbursable expenses" do not include any salary or overtime paid to any person on a regular or permanent payroll, including permanent part-time employees of any agency of the state.

(f) "Rescue" means search services, rescue services, or both search and rescue services.

(2) There is created the Search and Rescue Financial Assistance Program within the division.

(3) (a) The program shall be funded from the following revenue sources:

(i) any voluntary contributions to the state received for search and rescue operations;

(ii) money received by the state under Subsection (11) and under Sections 23-19-42, 41-22-34, and 73-18-24; and

(iii) appropriations made to the program by the Legislature.

(b) All money received from the revenue sources in Subsections (3)(a)(i) and (ii) shall be deposited into the General Fund as a dedicated credit to be used solely for the purposes under this section.

(c) All funding for the program is nonlapsing.

(4) The director shall use the money to reimburse counties for all or a portion of each county's reimbursable expenses for search and rescue operations, subject to:

(a) the approval of the Search and Rescue Advisory Board as provided in Section 53-2a-1104;

(b) money available in the program; and

(c) rules made under Subsection (7).

(5) Program money may not be used to reimburse for any paid personnel costs or paid man hours spent in emergency response and search and rescue related activities.

(6) The Legislature finds that these funds are for a general and statewide public purpose.

(7) The division, with the approval of the Search and Rescue Advisory Board, shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and consistent with this section:

(a) specifying the costs that qualify as reimbursable expenses;

(b) defining the procedures of counties to submit expenses and be reimbursed;

(c) defining a participant in the assistance card program, including:

(i) individuals; and

(ii) families and organized groups who qualify as participants;

(d) defining the procedure for issuing a card to a participant;

(e) defining excluded expenses that may not be reimbursed under the program, including medical expenses;

(f) establishing the card renewal cycle for the Utah Search and Rescue Assistance Card Program;

(g) establishing the frequency of review of the fee schedule;

(h) providing for the administration of the program; and

(i) providing a formula to govern the distribution of available money among the counties for uncompensated search and rescue expenses based on:

(i) the total qualifying expenses submitted;

(ii) the number of search and rescue incidents per county population;

(iii) the number of victims that reside outside the county; and

(iv) the number of volunteer hours spent in each county in emergency response and search and rescue related activities per county population.

(8) (a) The division shall, in consultation with the Outdoor Recreation Office, establish the fee schedule of the Search and Rescue Assistance Card under Subsection 63J-1-504(6).

(b) The division shall provide a discount of not less than 10% of the card fee under Subsection (8)(a) to a person who has paid a fee under Section 23-19-42, 41-22-34, or 73-18-24 during the same calendar year in which the person applies to be a participant in the assistance card program.

(9) (a) Counties may bill reimbursable expenses to an individual for costs incurred for the rescue of an individual, if the individual is not a participant in the Utah Search and Rescue Assistance Card Program.

(b) Counties may bill a participant for reimbursable expenses for costs incurred for the rescue of the participant if the participant is found by the rescuing county to have acted recklessly or to have intentionally created a situation resulting in the need for a county to provide rescue service for the participant.

(10) (a) There is created the Utah Search and Rescue Assistance Card Program. The program is located within the division.

(b) The program may not be utilized to cover any expenses, such as medically related expenses, that are not reimbursable expenses related to the rescue.

(11) (a) To participate in the program, a person shall purchase a Search and Rescue Assistance Card from the division by paying the fee as determined by the division in Subsection (8).

(b) The money generated by the fees shall be deposited into the General Fund as a dedicated credit for the Search and Rescue Financial Assistance Program created in this section.

(c) Participation and payment of fees by a person under Sections 23-19-42, 41-22-34, and 73-18-24 do not constitute purchase of a card under this section.

(12) The division shall consult with the Outdoor Recreation Office regarding:

(a) administration of the assistance card program; and

(b) outreach and marketing strategies.

(13) Pursuant to Subsection 31A-1-103(7), the Utah Search and Rescue Assistance Card Program under this section is exempt from being considered [~~an~~] insurance [~~program under Subsection 31A-1-301(86)~~] as that term is defined in Section 31A-1-301.

Section 39. Section **58-16a-601** is amended to read:

58-16a-601. Scope of practice.

(1) An optometrist may:

(a) provide optometric services not specifically prohibited under this chapter or division rules if the services are within the optometrist's training, skills, and scope of competence; and

(b) prescribe or administer pharmaceutical agents for the eye and its adnexa, including oral agents, subject to the following conditions:

(i) an optometrist may prescribe oral antibiotics for only eyelid related ocular conditions or diseases, and other ocular conditions or diseases specified by division rule; and

(ii) an optometrist may administer or prescribe a hydrocodone combination drug, or a Schedule III controlled substance, as defined in Section 58-37-4, only if:

(A) the substance is administered or prescribed for pain of the eye or adnexa;

(B) the substance is administered orally or topically or is prescribed for oral or topical use;

(C) the amount of the substance administered or prescribed does not exceed a 72-hour quantity; and

(D) if the substance is prescribed, the prescription does not include refills.

(2) An optometrist may not:

(a) perform surgery, including laser surgery; or

(b) prescribe or administer a Schedule II controlled substance, as defined in Section 58-37-4, except for a hydrocodone combination drug, if so scheduled and prescribed or administered in accordance with Subsection (1)(b).

(3) For purposes of Sections [~~31A-22-617 and~~] 31A-22-618 and 31A-45-303, an optometrist is a health care provider.

Section 40. Section **63I-2-231** is amended to read:

63I-2-231. Repeal dates, Title 31A.

(1) Section 31A-22-315.5 is repealed July 1, 2019.

(2) Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements is repealed July 1, 2019.

(3) Title 31A, Chapter 30, Part 3, Individual and Small Employer Risk Adjustment Act is repealed July 1, 2019.

[~~(2)~~] (4) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed December 31, 2018.

Section 41. Section **63N-11-104** is amended to read:

63N-11-104. Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The [~~consumer health office~~] Office of Consumer Health Services shall:

[~~(a) in cooperation with the Insurance Department, the Department of Health, and the~~

~~Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63N-11-107, create a Health Insurance Exchange that:~~]

[~~(i) provides information to consumers about private and public health programs for which the consumer may qualify;~~]

[~~(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange; and~~]

[~~(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;~~]

[~~(b) contract with one or more private vendors for:~~]

[~~(i) administration of the enrollment process on the Health Insurance Exchange, including establishing a mechanism for consumers to compare health benefit plan features on the exchange and filter the plans based on consumer preferences;~~]

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

[~~(iii) establishing a call center in accordance with Subsection (4);~~]

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

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

[~~(e) include in the annual written report described in Section 63N-1-301, a report on the operations of the Health Insurance Exchange required by this chapter; and~~]

[~~(f) in accordance with Subsection (3), provide a form to a small employer that certifies:~~]

[~~(i) that the small employer offered a qualified health plan to the small employer's employees; and~~]

[~~(ii) the period of time within the taxable year in which the small employer maintained~~

~~the qualified health plan coverage.~~]

[~~(3) The form required by Subsection (2)(f) shall be provided to a small employer if:~~]

[~~(a) the small employer selected a qualified health plan on the small employer health exchange created by this section; or~~]

[~~(b) (i) the small employer selected a health plan in the small employer market that is not offered through the exchange created by this section; and~~]

[~~(ii) the issuer of the health plan selected by the small employer submits to the office, in a form and manner required by the office:~~]

[~~(A) an affidavit from a member of the American Academy of Actuaries stating that based on generally accepted actuarial principles and methodologies the issuer's health plan meets the benefit and actuarial requirements for a qualified health plan under PPACA as defined in Section 31A-1-301; and~~]

[~~(B) an affidavit from the issuer that includes the dates of coverage for the small employer during the taxable year.~~]

[~~(4) A call center established by the consumer health office:~~]

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

[~~(b) may not:~~]

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

[~~(ii) receive producer compensation through the Health Insurance Exchange; and~~]

[~~(iii) be designated as the default producer for an employer group that enters the Health Insurance Exchange without a producer.~~]

[~~(5) The consumer health office:~~]

[~~(a) may not:~~]

[~~(i) regulate health insurers, health insurance plans, health insurance producers, or health insurance premiums charged in the exchange;~~]

[~~(ii) adopt administrative rules, except as provided in Section 63N-11-107; or~~]

[~~(iii) act as an appeals entity for resolving disputes between a health insurer and an insured;~~]

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

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

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

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

[~~(iv) funding the call center; and~~]

[~~(c) shall separately itemize the fee established under Subsection (5)(b) as part of the cost displayed for the employer selecting coverage on the exchange.~~]

(a) carry out the duties described in Section 63N-11-103;

(b) maintain the services provided by the office for the Avenue H small employer health insurance exchange until operations of Avenue H end under Subsection (2)(d);

(c) beginning July 1, 2017, enroll or renew a small employer group with a single insurer selected by the small employer, while allowing for employee choice among health benefit plans offered by the single insurer selected by the small employer; and

(d) take steps necessary to wind down the operations of the Avenue H small employer health insurance exchange effective July 1, 2018.

Section 42. **Health Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

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

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

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

(2) (a) The president of the Senate shall designate a member of the Senate appointed

under Subsection (1)(a) as a cochair of the task force.

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

(3) In conducting the task force's business, the task force shall comply with the rules of legislative interim committees.

(4) Salaries and expenses of the members of the task force shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Legislator Compensation.

(5) The Office of Legislative Research and General Counsel shall provide staff support to the task force.

Section 43. **Duties -- Interim report.**

(1) The task force shall review and make recommendations on the following issues:

(a) the need for state statutory and regulatory changes in response to federal actions affecting health care;

(b) Medicaid and reforms to the Medicaid program;

(c) options for increasing state flexibility, including the use of federal waivers;

(d) the state's health insurance marketplace;

(e) combining managed care organizations and health insurers into a guaranty association that includes only health insurers;

(f) health insurance code modifications;

(g) insurance network adequacy standards and balance billing;

(h) access to health care for medically underserved populations in the state; and

(i) the state's strategic plan for health system reform in Section 63N-11-105.

(2) A final report, including any proposed legislation, shall be presented to the Business and Labor Interim Committee and Health and the Human Services Interim Committee before November 30, 2017, and November 30, 2018.

Section 44. **Repealer.**

This bill repeals:

Section **31A-22-721, A health benefit plan for a plan sponsor -- Discontinuance**

and nonrenewal.

Section **31A-30-107, Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.**

Section **31A-30-107.1, Individual discontinuance and nonrenewal.**

Section **31A-30-107.3, Discontinuance and nonrenewal limitations and conditions.**

Section **31A-30-116, Essential health benefits.**

Section **63N-11-107, Health benefit plan information on Health Insurance Exchange -- Insurer transparency.**

Section 45. **Appropriation.**

The following sums of money are appropriated for the fiscal year beginning July 1, 2017, and ending June 30, 2018. These are additions to amounts previously appropriated for fiscal year 2018. Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, the Legislature appropriates the following sums of money from the funds or accounts indicated for the use and support of the government of the state of Utah.

ITEM 1

To Legislature - Senate

From General Fund, One-time $20,000

Schedule of Programs:

Administration $20,000

ITEM 2

To Legislature - House of Representatives

From General Fund, One-time $34,000

Schedule of Programs:

Administration $34,000

Section 46. **Repeal date.**

The Health Reform Task Force created in Sections 42 and 43 is repealed January 1, 2019.

Section 47. **Effective date.**

(1) Except as provided in Subsections (2) and (3), this bill takes effect on May 9, 2017.

(2) The actions affecting the following sections take effect on January 1, 2018:

(a) Section 31A-22-610.1;

(b) Section 31A-22-618;

(c) Section 31A-22-618.5;

(d) Section 31A-22-627;

(e) Section 31A-22-635;

(f) Section 31A-22-642;

(g) Section 31A-45-101;

(h) Section 31A-45-102;

(i) Section 31A-45-103;

(j) Section 31A-45-201;

(k) Section 31A-45-301;

(l) Section 31A-45-302;

(m) Section 31A-45-303;

(n) Section 31A-45-304;

(o) Section 31A-45-401;

(p) Section 31A-45-402;

(q) Section 31A-45-501;

(r) Section 49-20-407; and

(s) Section 58-16a-601.

(3) The repeal of Section 63N-11-107 takes effect on July 1, 2018.