

PLEASE NOTE:  
THIS DOCUMENT INCLUDES BOTH THE BILL AND ALSO A TRANSMITTAL LETTER  
THAT CONTAINS PASSED AMENDMENTS BUT NOT INCORPORATED INTO THE  
BILL.



# House of Representatives *State of Utah*

UTAH STATE CAPITOL COMPLEX • 350 STATE CAPITOL  
P.O. BOX 145030 • SALT LAKE CITY, UTAH 84114-5030 • (801) 538-1029

July 20, 2011 (3:35pm)

Mr. President:

The House passed **H.B. 2003**, INSURANCE AMENDMENTS, by Representative J. Dunnigan, with the following amendments:

1. *Page 7, Lines 206 through 213:*

206 (6) The small employer carrier may not use case characteristics other than the  
207 following:  
208 (a) age of the employee, [~~as determined at the beginning of the plan year, limited~~  
209 ~~to:~~] in  
210 accordance with Subsection (7);  
211 (b) geographic area;  
212 (c) family composition in accordance with Subsection (9); ~~{and}~~  
213 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee  
and  
214 spouse ; and  
(e) for an individual age 65 and older, whether the employer policy is primary  
or secondary to Medicare .

2. *Page 8, Line 214:*

214 (7) Age ~~{shall be determined at the beginning of the plan year}~~ , limited to:

3. *Page 14, Lines 404 through 407:*

404 (b) the Health Insurance Exchange shall provide [~~an employer who is participating~~  
405 ~~in~~  
406 ~~the defined contribution arrangement market of the Health Insurance Exchange and the~~  
407 ~~an~~  
408 employer and the employer's producer with premium renewal rates at least 60 days prior  
409 to [a]  
410 the group's renewal date for a plan offered under Part 2, Defined Contribution  
411 Arrangements. .

**H.B. 2003**

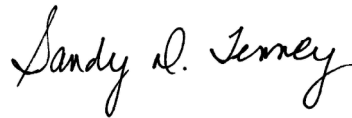
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Page 3

**(3) An insurer does not have to provide additional notice of premium renewal rates to the employer or the employer's producer if the Health Insurance Exchange provides notice in accordance with Subsection (2)(b).**

and it is transmitted to the Senate for consideration.

Respectfully,

A handwritten signature in cursive script that reads "Sandy D. Tenney".

Sandy D. Tenney  
Chief Clerk

1 **INSURANCE AMENDMENTS**

2 2011 SECOND SPECIAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: J. Stuart Adams

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6  
7 **LONG TITLE**

8 **General Description:**

9 This bill amends the provisions related to health benefit plans in the Insurance Code.

10 **Highlighted Provisions:**

11 This bill:

- 12 ▶ amends provisions related to unfair marketing practices by insurance producers;
- 13 ▶ amends the case characteristics a small employer carrier may use when establishing
- 14 health insurance premium rates for a small employer group;
- 15 ▶ amends the calculation of premium cost for family coverage in the small employer
- 16 group market by:
- 17 • allowing a carrier to use either four, five, or six rate tiers based on family size
  - 18 for plans offered outside of the Health Insurance Exchange; and
  - 19 • limiting a carrier to four rate tiers based on family size for plans offered in the
  - 20 defined contribution market on the Health Insurance Exchange;
- 21 ▶ authorizes the Insurance Department actuary to allow different rating practices
- 22 related to family tiering in and out of the Health Insurance Exchange;
- 23 ▶ amends provisions that require notice to a small employer group of the risk factor
- 24 used to calculate a group's health insurance premium; and
- 25 ▶ makes technical amendments.

26 **Money Appropriated in this Bill:**

27 This bill appropriates:

28           ▶ \$35,000 from the General Fund, One-time, for fiscal year 2011-12 only, to the  
29 Insurance Department - Risk Adjuster.

30 **Other Special Clauses:**

31           This bill provides an immediate effective date.

32 **Utah Code Sections Affected:**

33 AMENDS:

34           **31A-23a-402**, as last amended by Laws of Utah 2011, Chapters 62 and 289

35           **31A-30-106.1**, as last amended by Laws of Utah 2011, Chapters 284 and 400

36           **31A-30-115**, as enacted by Laws of Utah 2011, Chapter 400

37           **31A-30-202.5**, as enacted by Laws of Utah 2010, Chapter 68

38           **31A-30-207**, as last amended by Laws of Utah 2011, Chapter 400

39           **31A-30-211**, as enacted by Laws of Utah 2011, Chapter 400



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

42           Section 1. Section **31A-23a-402** is amended to read:

43           **31A-23a-402. Unfair marketing practices -- Communication -- Unfair**  
44 **discrimination -- Coercion or intimidation -- Restriction on choice.**

45           (1) (a) (i) Any of the following may not make or cause to be made any communication  
46 that contains false or misleading information, relating to an insurance product or contract, any  
47 insurer, or any licensee under this title, including information that is false or misleading  
48 because it is incomplete:

49           (A) a person who is or should be licensed under this title;

50           (B) an employee or producer of a person described in Subsection (1)(a)(i)(A);

51           (C) a person whose primary interest is as a competitor of a person licensed under this  
52 title; and

53           (D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

54           (ii) As used in this Subsection (1), "false or misleading information" includes:

55           (A) assuring the nonobligatory payment of future dividends or refunds of unused  
56 premiums in any specific or approximate amounts, but reporting fully and accurately past  
57 experience is not false or misleading information; and

58           (B) with intent to deceive a person examining it:

- 59 (I) filing a report;
- 60 (II) making a false entry in a record; or
- 61 (III) wilfully refraining from making a proper entry in a record.
- 62 (iii) A licensee under this title may not:
- 63 (A) use any business name, slogan, emblem, or related device that is misleading or
- 64 likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee
- 65 already in business; or
- 66 (B) use any advertisement or other insurance promotional material that would cause a
- 67 reasonable person to mistakenly believe that a state or federal government agency, including
- 68 the Health Insurance Exchange, also called the "Utah Health Exchange," created in Section
- 69 63M-1-2504, the Comprehensive Health Insurance Pool created in Chapter 29, Comprehensive
- 70 Health Insurance Pool Act, and the Children's Health Insurance Program created in Title 26,
- 71 Chapter 40, Utah Children's Health Insurance Act:
- 72 (I) is responsible for the insurance sales activities of the person;
- 73 (II) stands behind the credit of the person;
- 74 (III) guarantees any returns on insurance products of or sold by the person; or
- 75 (IV) is a source of payment of any insurance obligation of or sold by the person.
- 76 (iv) A person who is not an insurer may not assume or use any name that deceptively
- 77 implies or suggests that person is an insurer.
- 78 (v) A person other than persons licensed as health maintenance organizations under
- 79 Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to
- 80 itself.
- 81 (b) A licensee's violation creates a rebuttable presumption that the violation was also
- 82 committed by the insurer if:
- 83 (i) the licensee under this title distributes cards or documents, exhibits a sign, or
- 84 publishes an advertisement that violates Subsection (1)(a), with reference to a particular
- 85 insurer:
- 86 (A) that the licensee represents; or
- 87 (B) for whom the licensee processes claims; and
- 88 (ii) the cards, documents, signs, or advertisements are supplied or approved by that
- 89 insurer.

90 (2) (a) A title insurer or producer or any officer or employee of either may not pay,  
91 allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining  
92 any title insurance business:

93 (i) any rebate, reduction, or abatement of any rate or charge made incident to the  
94 issuance of the title insurance;

95 (ii) any special favor or advantage not generally available to others; or

96 (iii) any money or other consideration, except if approved under Section 31A-2-405; or

97 (iv) material inducement.

98 (b) "Charge made incident to the issuance of the title insurance" includes escrow  
99 charges, and any other services that are prescribed in rule by the Title and Escrow Commission  
100 after consultation with the commissioner and subject to Section 31A-2-404.

101 (c) An insured or any other person connected, directly or indirectly, with the  
102 transaction may not knowingly receive or accept, directly or indirectly, any benefit referred to  
103 in Subsection (2)(a), including:

104 [~~(A)~~] (i) a person licensed under Title 61, Chapter 2c, Utah Residential Mortgage  
105 Practices and Licensing Act;

106 [~~(B)~~] (ii) a person licensed under Title 61, Chapter 2f, Real Estate Licensing and  
107 Practices Act;

108 [~~(C)~~] (iii) a builder;

109 [~~(D)~~] (iv) an attorney; or

110 [~~(E)~~] (v) an officer, employee, or agent of a person listed in this Subsection (2)(c)(iii).

111 (3) (a) An insurer may not unfairly discriminate among policyholders by charging  
112 different premiums or by offering different terms of coverage, except on the basis of  
113 classifications related to the nature and the degree of the risk covered or the expenses involved.

114 (b) Rates are not unfairly discriminatory if they are averaged broadly among persons  
115 insured under a group, blanket, or franchise policy, and the terms of those policies are not  
116 unfairly discriminatory merely because they are more favorable than in similar individual  
117 policies.

118 (4) (a) This Subsection (4) applies to:

119 (i) a person who is or should be licensed under this title;

120 (ii) an employee of that licensee or person who should be licensed;

121 (iii) a person whose primary interest is as a competitor of a person licensed under this  
122 title; and

123 (iv) one acting on behalf of any person described in Subsections (4)(a)(i) through (iii).

124 (b) A person described in Subsection (4)(a) may not commit or enter into any  
125 agreement to participate in any act of boycott, coercion, or intimidation that:

126 (i) tends to produce:

127 (A) an unreasonable restraint of the business of insurance; or

128 (B) a monopoly in that business; or

129 (ii) results in an applicant purchasing or replacing an insurance contract.

130 (5) (a) (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an  
131 insurer or licensee under this chapter, another person who is required to pay for insurance as a  
132 condition for the conclusion of a contract or other transaction or for the exercise of any right  
133 under a contract.

134 (ii) A person requiring coverage may reserve the right to disapprove the insurer or the  
135 coverage selected on reasonable grounds.

136 (b) The form of corporate organization of an insurer authorized to do business in this  
137 state is not a reasonable ground for disapproval, and the commissioner may by rule specify  
138 additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from  
139 declining an application for insurance.

140 (6) A person may not make any charge other than insurance premiums and premium  
141 financing charges for the protection of property or of a security interest in property, as a  
142 condition for obtaining, renewing, or continuing the financing of a purchase of the property or  
143 the lending of money on the security of an interest in the property.

144 (7) (a) A licensee under this title may not refuse or fail to return promptly all indicia of  
145 agency to the principal on demand.

146 (b) A licensee whose license is suspended, limited, or revoked under Section  
147 31A-2-308, 31A-23a-111, or 31A-23a-112 may not refuse or fail to return the license to the  
148 commissioner on demand.

149 (8) (a) A person may not engage in an unfair method of competition or any other unfair  
150 or deceptive act or practice in the business of insurance, as defined by the commissioner by  
151 rule, after a finding that the method of competition, the act, or the practice:



- 152 (i) is misleading;
- 153 (ii) is deceptive;
- 154 (iii) is unfairly discriminatory;
- 155 (iv) provides an unfair inducement; or
- 156 (v) unreasonably restrains competition.

157 (b) Notwithstanding Subsection (8)(a), for purpose of the title insurance industry, the  
158 Title and Escrow Commission shall make rules, subject to Section 31A-2-404, that define an  
159 unfair method of competition or unfair or deceptive act or practice after a finding that the  
160 method of competition, the act, or the practice:

- 161 (i) is misleading;
- 162 (ii) is deceptive;
- 163 (iii) is unfairly discriminatory;
- 164 (iv) provides an unfair inducement; or
- 165 (v) unreasonably restrains competition.

166 Section 2. Section **31A-30-106.1** is amended to read:

167 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

168 (1) Premium rates for small employer health benefit plans under this chapter are  
169 subject to this section [~~for a health benefit plan that is issued or renewed, on or after July 1,~~  
170 ~~2011~~].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

208 (a) age of the employee, [~~as determined at the beginning of the plan year, limited to:~~] in  
209 accordance with Subsection (7);

210 (b) geographic area;

211 (c) family composition in accordance with Subsection (9); and

212 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee and  
213 spouse.

214 (7) Age shall be determined at the beginning of the plan year, limited to:

215 [(+)] (a) the following age bands:

216 [(A)] (i) less than 20;

217 [(B)] (ii) 20-24;

218 [(C)] (iii) 25-29;

219 [(D)] (iv) 30-34;

220 [(E)] (v) 35-39;

221 [(F)] (vi) 40-44;

222 [(G)] (vii) 45-49;

223 [(H)] (viii) 50-54;

224 [(I)] (ix) 55-59;

225 [(J)] (x) 60-64; and

226 [(K)] (xi) 65 and above; and

227 [(+)] (b) a standard slope ratio range for each age band, applied to each family

228 composition tier rating structure under Subsection [(6)(c)] (9)(b):

229 [(A)] (i) as developed by the commissioner by administrative rule; and

230 [(B)] (ii) not to exceed an overall ratio ~~[of 5:1; and]~~ as provided in Subsection (8).

231 (8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:

232 (i) 5:1 for plans renewed or effective before January 1, 2012; and

233 (ii) 6:1 for plans renewed or effective on or after January 1, 2012; and

234 [(C)] (b) the age slope ratios for each age band may not overlap[;].

235 [(b) geographic area;]

236 [(c) family] (9) Except as provided in Subsection 31A-30-207(2), family

237 composition[;] is limited to:

238 [(+)] (a) an overall ratio of ~~[5:1 or less; and]~~;

239 [(+)] (b) ~~a four~~

240 (i) 5:1 or less for plans renewed or effective before January 1, 2012; and

241 (ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and

242 (b) a tier rating structure that includes:

243 (i) four tiers that include:

244 (A) employee only;

- 245 (B) employee plus spouse;
- 246 (C) employee plus a [~~dependent or dependents~~] child or children; and
- 247 (D) a family, consisting of an employee plus spouse, and a [~~dependent or dependents~~]
- 248 child or children; [~~and~~]

249 [~~(d) gender of the employee or spouse.~~]  
 250 (ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:

- 251 (A) employee only;
- 252 (B) employee plus spouse;
- 253 (C) employee plus one child;
- 254 (D) employee plus two or more children; and
- 255 (E) employee plus spouse plus one or more children; or

256 (iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:

- 257 (A) employee only;
- 258 (B) employee plus spouse;
- 259 (C) employee plus one child;
- 260 (D) employee plus two or more children;
- 261 (E) employee plus spouse plus one child; and
- 262 (F) employee plus spouse plus two or more children.

263 [~~(7)~~] (10) If a health benefit plan is a health benefit plan into which the small employer  
 264 carrier is no longer enrolling new covered insureds, the small employer carrier shall use the  
 265 percentage change in the base premium rate, provided that the change does not exceed, on a  
 266 percentage basis, the change in the new business premium rate for the most similar health  
 267 benefit product into which the small employer carrier is actively enrolling new covered  
 268 insureds.

269 [~~(8)~~] (11) (a) A covered carrier may not transfer a covered insured involuntarily into or  
 270 out of a class of business.

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

- 274 (i) case characteristics;
- 275 (ii) claim experience;

276 (iii) health status; or

277 (iv) duration of coverage since issue.

278 ~~[(9)]~~ (12) (a) Each small employer carrier shall maintain at the small employer carrier's  
279 principal place of business a complete and detailed description of its rating practices and  
280 renewal underwriting practices, including information and documentation that demonstrate that  
281 the small employer carrier's rating methods and practices are:

282 (i) based upon commonly accepted actuarial assumptions; and

283 (ii) in accordance with sound actuarial principles.

284 (b) (i) Each small employer carrier shall file with the commissioner on or before April  
285 1 of each year, in a form and manner and containing information as prescribed by the  
286 commissioner, an actuarial certification certifying that:

287 (A) the small employer carrier is in compliance with this chapter; and

288 (B) the rating methods of the small employer carrier are actuarially sound.

289 (ii) A copy of the certification required by Subsection ~~[(9)]~~ (12)(b)(i) shall be retained  
290 by the small employer carrier at the small employer carrier's principal place of business.

291 (c) A small employer carrier shall make the information and documentation described  
292 in this Subsection ~~[(9)]~~ (12) available to the commissioner upon request.

293 ~~[(10)]~~ (13) (a) The commissioner shall ~~[, by July 1, 2010,]~~ establish rules in accordance  
294 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

295 (i) implement this chapter; and

296 (ii) assure that rating practices used by small employer carriers under this section and  
297 carriers for individual plans under Section 31A-30-106 ~~[, in effect on January 1, 2011,]~~ are  
298 consistent with the purposes of this chapter.

299 (b) The rules may:

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

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

305 ~~[(11)]~~ (14) Records submitted to the commissioner under this section shall be  
306 maintained by the commissioner as protected records under Title 63G, Chapter 2, Government

307 Records Access and Management Act.

308 Section 3. Section **31A-30-115** is amended to read:

309 **31A-30-115. Actuarial review of health benefit plans.**

310 (1) (a) The department shall conduct an actuarial review of rates submitted by small  
311 employer carriers:

312 (i) prior to the publication of the premium rates on the Health Insurance Exchange;

313 (ii) except as permitted by Subsection 31A-30-207(2), to determine if the [rates are]  
314 carrier is using the same rating and underwriting practices in both the defined contribution  
315 arrangement market in the Health Insurance Exchange and the defined benefit market offered  
316 outside the Health Insurance Exchange, in compliance with Subsection 31A-30-202.5(1)(b);

317 (iii) to verify the validity of the rates, underwriting and risk factors, and premiums of  
318 plans both in and outside of the Health Insurance Exchange;

319 (iv) to verify that insurers are pricing similar health benefit plans and groups the same  
320 in and out of the exchange, except as permitted by Subsection 31A-30-207(2); and

321 (v) as the department determines is necessary to oversee market conduct.

322 (b) The actuarial review by the department shall be funded from a fee:

323 (i) established by the department in accordance with Section 63J-1-504; and

324 (ii) paid by all small employer carriers participating in the defined contribution  
325 arrangement market and small employer carriers offering health benefit plans under [~~Chapter~~  
326 ~~30;~~] Part 1, Individual and Small Employer Group.

327 (c) The department shall:

328 (i) report aggregate data from the actuarial review to the risk adjuster board created in  
329 Section 31A-42-201; and

330 (ii) contact carriers, if the department determines it is appropriate, to:

331 (A) inform a carrier of the department's findings regarding the rates of a particular  
332 carrier; and

333 (B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

334 (d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

335 (2) (a) There is created in the General Fund a restricted account known as the "Health  
336 Insurance Actuarial Review Restricted Account."

337 (b) The Health Insurance Actuarial Review Restricted Account shall consist of money

338 received by the commissioner under this section.

339 (c) The commissioner shall administer the Health Insurance Actuarial Review  
340 Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use  
341 money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the  
342 actuarial review conducted by the department under this section.

343 Section 4. Section **31A-30-202.5** is amended to read:

344 **31A-30-202.5. Insurer participation in defined contribution arrangement market.**

345 (1) A small employer carrier who chooses to participate in the defined contribution  
346 arrangement market:

347 (a) shall offer the defined contribution arrangement health benefit plans required by  
348 Section 31A-30-205;

349 (b) may:

350 (i) offer additional defined contribution arrangement health benefit plans in the Health  
351 Insurance Exchange as permitted by Section 31A-30-205;

352 (ii) offer a defined benefit plan in the Health Insurance Exchange if the small employer  
353 carrier offers a defined contribution arrangement health benefit plan that is actuarially  
354 equivalent to the defined benefit plan that is offered in the Health Insurance Exchange; and

355 (iii) continue to offer defined benefit plans outside of the Health Insurance Exchange  
356 and the defined contribution arrangement market, if, except as provided in Subsection  
357 31A-30-207(2), the carrier uses the same rating and underwriting practices in both the defined  
358 contribution arrangement market in the Health Insurance Exchange and the defined benefit  
359 market outside the Health Insurance Exchange.

360 (2) A carrier that does not elect to participate in the defined contribution arrangement  
361 market by January 1, 2011, may not participate in the defined contribution arrangement market  
362 in the Health Insurance Exchange until January 1, 2013.

363 Section 5. Section **31A-30-207** is amended to read:

364 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**  
365 **contribution arrangement market.**

366 (1) [~~The~~] Except as provided in Subsection (2), rating and underwriting restrictions for  
367 [~~defined benefit plans and for the~~] defined contribution arrangement health benefit plans  
368 offered in the Health Insurance Exchange [~~defined contribution arrangement market~~] shall be in

369 accordance with Section 31A-30-106.1, and the plan adopted under Chapter 42, Defined  
370 Contribution Risk Adjuster Act.

371 (2) Notwithstanding the provisions of Subsections 31A-30-106.1(9)(b)(ii) and (iii), a  
372 carrier offering a defined contribution arrangement in the Health Insurance Exchange under  
373 this part:

374 (a) shall calculate rates based on a family tier rating structure that includes four tiers in  
375 compliance with Subsection 31A-30-106.1(9)(b)(i); and

376 (b) may not calculate rates based on a family tier rating structure that includes five or  
377 six tiers as described in Subsection 31A-30-106(9)(b)(ii) or (iii).

378 ~~[(2)]~~ (3) All insurers who participate in the defined contribution market shall:

379 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined  
380 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

381 (b) provide the risk adjuster board with:

382 (i) an employer group's risk factor; and

383 (ii) carrier enrollment data; and

384 (c) submit rates to the exchange that are net of commissions.

385 ~~[(3)]~~ (4) When an employer group enters the defined contribution arrangement market  
386 ~~[for either a defined contribution arrangement health benefit plan, or a defined benefit plan,]~~

387 and the employer group has a health plan with an insurer who is participating in the defined  
388 contribution arrangement market, the risk factor applied to the employer group when it enters  
389 the defined contribution arrangement market may not be greater than the employer group's  
390 renewal risk factor for the same group of covered employees and the same effective date, as  
391 determined by the employer group's insurer.

392 Section 6. Section **31A-30-211** is amended to read:

393 **31A-30-211. Insurer disclosure.**

394 (1) The Health Insurance Exchange shall provide an ~~[employer and an]~~ employer's  
395 producer with the group's risk factor used to calculate the employer group's premium at the  
396 time of:

397 (a) the initial offering of a health benefit plan; and

398 (b) the renewal of a health benefit plan.

399 (2) For health benefit plans that renew on or after March 1, 2012:



400 (a) a carrier [~~in the small employer market under Part 1, Individual and Small~~  
 401 ~~Employer Group;~~] shall provide an employer and the employer's producer with premium  
 402 renewal rates at least 60 days prior to the group's renewal date for a plan offered under Part 1,  
 403 Individual and Small Employer Group; and

404 (b) the Health Insurance Exchange shall provide [~~an employer who is participating in~~  
 405 ~~the defined contribution arrangement market of the Health Insurance Exchange and the]~~ an  
 406 employer and the employer's producer with premium renewal rates at least 60 days prior to [a]  
 407 the group's renewal date for a plan offered under Part 2, Defined Contribution Arrangements.

408 Section 7. **Appropriation.**

409 Under the terms and conditions of Utah Code Title 63J, Chapter 1, Budgetary  
 410 Procedures Act, the following sums of money are appropriated one-time only from the funds or  
 411 fund accounts indicated for the use and support of the government of the state for the fiscal  
 412 year beginning July 1, 2011, and ending June 30, 2012.

413 To the Insurance Department - Risk Adjuster

414 <u>From General Fund, One-time</u>	\$35,000
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415 Schedule of Programs:

416 <u>Risk Adjuster</u>	\$35,000
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417 Section 8. **Effective date.**

418 If approved by two-thirds of all the members elected to each house, this bill takes effect  
 419 upon approval by the governor, or the day following the constitutional time limit of Utah  
 420 Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto,  
 421 the date of veto override.

**Legislative Review Note**  
 as of 7-19-11 10:23 AM

**Office of Legislative Research and General Counsel**

# FISCAL NOTE

H.B. 2003

SHORT TITLE: Insurance Amendments

SPONSOR: Dunnigan, J.

2011 SECOND SPECIAL SESSION

## STATE GOVERNMENT (UCA 36-12-13(2)(b))

Enactment of this bill would appropriate \$35,000 in One-time General Fund to the Insurance Department for implementation of the provisions of the bill.

### STATE BUDGET DETAIL TABLE

	FY 2011	FY 2012	FY 2013
Revenue	\$0	\$0	\$0
Expenditure:			
General Fund, One-Time	\$0	\$35,000	\$0
Total Expenditure	\$0	\$35,000	\$0
Net Impact, All Funds (Rev.-Exp.)	\$0	(\$35,000)	\$0
Net Impact, General/Education Funds	\$0	(\$35,000)	\$0

## LOCAL GOVERNMENTS (UCA 36-12-13(2)(c))

Enactment of this bill likely will not result in direct, measurable costs for local governments.

## DIRECT EXPENDITURES BY UTAH RESIDENTS AND BUSINESSES (UCA 36-12-13(2)(d))

Enactment of this bill likely will not result in direct, measurable expenditures by Utah residents or businesses.