INSURANCE AMENDMENTS

2011 SECOND SPECIAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: J. Stuart Adams

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

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

Money Appropriated in this Bill:

This bill appropriates:

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

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

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

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

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

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

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

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

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

Section 1. 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 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," created in Section 63M-1-2504, 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 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 or producer or any officer or employee of either 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; or

(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:

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

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

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

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

[~~(E)~~] (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 2. Section **31A-30-106.1** is amended to read:

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

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

~~2011~~].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) geographic area;

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

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

(e) for an individual age 65 and older, whether the employer policy is primary or secondary to Medicare.

(7) Age limited to:

[~~(i)~~] (a) the following age bands:

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

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

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

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

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

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

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

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

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

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

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

[~~(ii)~~] (b) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection [~~(6)(c)~~] (9)(b):

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

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

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

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

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

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

[~~(b) geographic area;~~]

[~~(c) family~~] (9) Except as provided in Subsection 31A-30-207(2), family composition[~~;~~] is limited to:

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

[~~(ii) a four~~]

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

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

(b) a tier rating structure that includes:

(i) four tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a [~~dependent or dependents~~] child or children; and

(D) a family, consisting of an employee plus spouse, and a [~~dependent or dependents~~] child or children; [~~and~~]

[~~(d) gender of the employee or spouse.~~]

(ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children; and

(E) employee plus spouse plus one or more children; or

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

(A) employee only;

(B) employee plus spouse;

(C) employee plus one child;

(D) employee plus two or more children;

(E) employee plus spouse plus one child; and

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

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

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

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

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

[~~(9)~~] (12) (a) Each small employer carrier shall maintain at the small employer carrier's principal place of business a complete and detailed description of its rating practices and

renewal underwriting practices, including information and documentation that demonstrate that the small employer carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

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

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

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

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

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

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

(i) implement this chapter; and

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

(b) The rules may:

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

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

[~~(11)~~] (14) 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 3. Section **31A-30-115** is amended to read:

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

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

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

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

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

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

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

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

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

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

(c) The department shall:

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

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

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

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

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

(2) (a) There is created in the General Fund a restricted account known as the "Health

Insurance Actuarial Review Restricted Account."

(b) The Health Insurance Actuarial Review Restricted Account shall consist of money received by the commissioner under this section.

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

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

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

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

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

(b) may:

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

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

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

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

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

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

(1) [~~The~~] Except as provided in Subsection (2), rating and underwriting restrictions for [~~defined benefit plans and for the~~] defined contribution arrangement health benefit plans offered in the Health Insurance Exchange [~~defined contribution arrangement market~~] shall be in accordance with Section 31A-30-106.1, and the plan adopted under Chapter 42, Defined Contribution Risk Adjuster Act.

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

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

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

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

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

(b) provide the risk adjuster board with:

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

(ii) carrier enrollment data; and

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

[~~(3)~~] (4) When an employer group enters the defined contribution arrangement market [~~for either a defined contribution arrangement health benefit plan, or a defined benefit plan,~~] and the employer group has a health plan with an insurer who is participating in the defined contribution arrangement market, the risk factor applied to the employer group when it enters the defined contribution arrangement market may not be greater than the employer group's renewal risk factor for the same group of covered employees and the same effective date, as determined by the employer group's insurer.

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

31A-30-211. Insurer disclosure.

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

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

(b) the renewal of a health benefit plan.

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

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

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

(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).

Section 7. **Appropriation.**

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

To the Insurance Department - Risk Adjuster

From General Fund, One-time $35,000

Schedule of Programs:

Risk Adjuster $35,000