Part 7
Group Accident and Health Insurance

31A-22-701 Groups eligible for group or blanket insurance.

(1) As used in this section, "association group" means a lawfully formed association of individuals or business entities that:
  (a) purchases insurance on a group basis on behalf of members; and
  (b) is formed and maintained in good faith for purposes other than obtaining insurance.
(2) A group accident and health insurance policy may be issued to:
  (a) a group:
    (i) to which a group life insurance policy may be issued under Sections 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, 31A-22-507, and 31A-22-509; and
    (ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;
  (b) an association group that:
    (i) has been actively in existence for at least five years;
    (ii) has a constitution and bylaws;
    (iii) is formed and maintained in good faith for purposes other than obtaining insurance;
    (iv) does not condition membership in the association group on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;
    (v) makes accident and health insurance coverage offered through the association group available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;
    (vi) does not make accident and health insurance coverage offered through the association group available other than in connection with a member of the association group; and
    (vii) is actuarially sound; or
  (c) a group specifically authorized by the commissioner under Section 31A-22-509, upon a finding that:
    (i) authorization is not contrary to the public interest;
    (ii) the group is actuarially sound;
    (iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;
    (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups;
    (v) the group would not present hazards of adverse selection;
    (vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and
    (vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance.
(3) A blanket accident and health insurance policy:
  (a) covers a defined class of persons;
  (b) may not be offered or underwritten on an individual basis;
  (c) shall cover only a group that is:
    (i) actuarially sound; and
    (ii) formed and maintained in good faith for a purpose other than obtaining insurance; and
  (d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;
(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;
(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;
(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;
(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;
(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;
(vii) a newspaper or other publisher, as policyholder, covering its carriers;
(viii) an association, including a labor union, that has a constitution and bylaws and that is organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; and
(ix) any other class of risks that, in the judgment of the commissioner, may be properly eligible for blanket accident and health insurance.
(4) The judgment of the commissioner may be exercised on the basis of:
(a) individual risks;
(b) a class of risks; or
(c) both Subsections (4)(a) and (b).

Amended by Chapter 284, 2011 General Session

31A-22-702 Adjustment of premium rate and application of dividends or rate reductions.

Any group accident and health insurance policy may provide for the adjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any policy of group accident and health insurance, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, including expenditures made in connection with the administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members unless the insured employee or member explicitly elects otherwise.

Amended by Chapter 116, 2001 General Session

31A-22-715 Alcohol and drug dependency treatment.

(1) An insurer 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), an insurer may require an inpatient facility to be accredited by the following:
(a) the joint commission; and
(b) one other nationally recognized accrediting agency.

Amended by Chapter 138, 2016 General Session

31A-22-716 Required provision for notice of termination.
(1) Every policy for group or blanket accident and health coverage issued or renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior written notice of termination to each employee or group member and to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination.
(2) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide a sample notice to the policyholder at least once a year.
(3) For the purpose of compliance with federal law and the Health Insurance Portability and Accountability Act, all health benefit plans, health insurers, and student health plans shall provide a certificate of creditable coverage to each covered person upon the person's termination from the plan as soon as reasonably possible.

Amended by Chapter 284, 2011 General Session
Amended by Chapter 297, 2011 General Session

31A-22-717 Provisions pertaining to service members and their families affected by mobilization into the armed forces.
For any group or blanket accident and health coverage, an insurer:
(1) may not refuse to reinstate an insured or his family whose coverage lapsed due to the insured's mobilization into the United States armed forces provided application is made within 180 days of release from active duty;
(2) shall reinstate an insured in full upon payment of the first premium without the requirement of a waiting period or exclusion for preexisting conditions or any other underwriting requirements that were covered previously; and
(3) may not increase the insured's premium in excess of what it would have been increased in the normal course of time had the insured not been mobilized into the United States armed forces.

Amended by Chapter 108, 2004 General Session

31A-22-718 Dependent coverage.
No group policy that provides coverage to children of group members may deny eligibility for coverage to a child solely because the child does not reside with the group member or solely because the child is solely dependent on a former spouse of the group member rather than on the

group member. A child who does not reside with the group member may be excluded on the same basis as children who do reside with the group member.

Enacted by Chapter 344, 1995 General Session

31A-22-719 Mastectomy coverage.

(1) A group policy subject to Section 31A-22-630 may not deny a person's eligibility or continued eligibility to enroll or renew coverage under the terms of the group policy plan solely for the purpose of avoiding the requirements of this section or Section 31A-22-630.

(2) A group policy subject to Section 31A-22-630 may not do any of the following to induce a provider to provide care to an insured in a manner inconsistent with this section or Section 31A-22-630:

(a) penalize or otherwise reduce or limit the reimbursement of an attending provider; or

(b) provide incentives to an attending provider whether or not the incentives are monetary.

Enacted by Chapter 114, 2000 General Session

31A-22-721 A health benefit plan for a plan sponsor -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a 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) 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) 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.

(3) 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 product delivered or issued for delivery in this state;

(ii)

(A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, and dependent of a plan sponsor or 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) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of plan sponsors or employees;
(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:
(I) by the insurer in the market; or
(II) in the case of a large employer, any other health benefit plan 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, the insurer 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) any health status-related factor relating to a new participant or beneficiary who may become eligible for coverage; or
(e) the insurer:
(i) elects to discontinue all of the insurer's health benefit plans:
(A) in the small employer market; or
(B) the large employer market; or
(C) both the small and large employer markets; and
(ii)
(A) provides notice of the discontinuance 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) at least 30 business days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of a plan sponsor or employee;
(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; 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)
(a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:
(i) engages in an act or practice that constitutes fraud in connection with the coverage; or
(ii) makes an intentional misrepresentation of material fact in connection with the coverage.
(b) An eligible employee that is discontinued under Subsection (7)(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)(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) because of a fraud or misrepresentation that relates to health status.

(8)

(a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new business in such market in this state for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The commissioner may waive the prohibition under Subsection (8)(a) when the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(9) If an insurer is doing business in one established geographic service area of the state, this section applies only to the insurer's operations in that geographic service area.

(10) 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 a particular product or service.

(11) 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.

(12)

(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 less 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.

(13) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-22-722 Utah mini-COBRA benefits for employer group coverage.

(1) An insured may extend the employee's coverage under the current employer's group policy for a period of 12 months, except as provided in Subsections (2) and 31A-22-722.5(4). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;
(d) death;
(e) divorce or legal separation;
(f) loss of dependent status;
(g) sabbatical;
(h) a disability;
(i) leave of absence; or
(j) reduction of hours.

(2)
(a) Notwithstanding Subsection (1), an employee may not extend coverage under the current employer's group insurance policy if the employee:
(i) fails to pay premiums or contributions in accordance with the terms of the insurance policy;
(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;
(iii) performs an act or practice that constitutes fraud in connection with the coverage;
(iv) makes an intentional misrepresentation of material fact under the terms of the coverage;
(v) is terminated from employment for gross misconduct;
(vi) is not continuously covered under the current employer's group policy for a period of three months immediately before the termination of the insurance policy due to an event set forth in Subsection (1);
(vii) is eligible for an extension of coverage required by federal law;
(viii) establishes residence outside of this state;
(ix) moves out of the insurer's service area;
(x) is eligible for similar coverage under another group insurance policy; or
(xi) has the employee's coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).
(b) The right to extend coverage under Subsection (1) applies to spouse or dependent coverage, including a surviving spouse or dependents whose coverage under the insurance policy terminates by reason of the death of the employee or member.

(3)
(a) The employer shall notify the following in writing of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made:
(i) a terminated insured;
(ii) an ex-spouse of an insured; or
(iii) if Subsection (2)(b) applies:
(A) a surviving spouse; and
(B) the guardian of surviving dependents, if different from a surviving spouse.
(b) The notification required in Subsection (3)(a) shall be sent first class mail within 30 days after the termination date of the group coverage to:
(i) the terminated insured's home address as shown on the records of the employer;
(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;
(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and
(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and
(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.
(5) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.
(6) Except as provided in this Subsection (6), coverage extends without interruption for 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:
(a) elects to extend group coverage within 60 days of losing group coverage; and
(b) tenders the amount required to the employer or insurer.
(7) The insured's coverage may be terminated before 12 months if the terminated insured:
(a) establishes residence outside of this state;
(b) moves out of the insurer's service area;
(c) fails to pay premiums or contributions in accordance with the terms of the insurance policy, including any timeliness requirements;
(d) performs an act or practice that constitutes fraud in connection with the coverage;
(e) makes an intentional misrepresentation of material fact under the terms of the coverage;
(f) becomes eligible for similar coverage under another group insurance policy; or
(g) has the coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).
(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group insurance policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:
(a) for the balance of the period the terminated insured would have extended coverage under the replaced group insurance policy; and
(b) if the terminated insured is otherwise eligible for extension of coverage.

Amended by Chapter 319, 2013 General Session

31A-22-722.5 Mini-COBRA election -- American Recovery and Reinvestment Act.
(1)
(a) If the provisions of Subsection (1)(b) are met, an individual has a right to contact the individual's employer or the insurer for the employer to participate in a transition period for mini-COBRA benefits under Section 31A-22-722 in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended.
(b) An individual has the right under Subsection (1)(a) if the individual:
(i) was involuntarily terminated from employment during the period of time identified in Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended;
(ii) is eligible for COBRA premium assistance under Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended;
(iii) was eligible for Utah mini-COBRA as provided in Section 31A-22-722 at the time of termination;
(iv) elected Utah mini-Cobra; and

(v) voluntarily dropped coverage, which includes dropping coverage through non-payment of premiums, between December 1, 2009 and February 1, 2010.

(2)

(a) An individual or the employer of the individual shall contact the insurer and inform the insurer that the individual wants to maintain coverage and pay retroactive premiums under a transition period for mini-COBRA coverage in accordance with the provisions of Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended.

(b) An individual or an employer on behalf of an eligible individual shall submit the applicable forms and premiums for coverage under Subsection (1) to the insurer in accordance with the provisions of Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), as amended.

(3) An insured has the right to extend the employee's coverage under mini-cobra with the current employer's group policy beyond the 12 months to the period of time the insured is eligible to receive assistance in accordance with Section 3001 of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5) as amended.

(4) An insurer that violates this section is subject to penalties in accordance with Section 31A-2-308.

Amended by Chapter 297, 2011 General Session
Amended by Chapter 340, 2011 General Session

31A-22-725 Special enrollment periods relating to Medicaid and Children's Health Insurance Program.

(1) A person is eligible to enroll for coverage under the terms of an employer's group health benefit plan if:

(a) the person is:

(i) an employee who is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; or

(ii) a dependent of an employee, if the dependent is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; and

(b) the conditions of either Subsection (2) or (3) are met.

(2) Subsection (1) applies if:

(a) the employee or dependent is covered under:

(i) a Medicaid health benefit plan under Title XIX of the Social Security Act; or

(ii) a state child health benefit plan under Title XXI of the Social Security Act;

(b) coverage of the employee or dependent described in Subsection (2)(a) is terminated as a result of loss of eligibility for the coverage; and

(c) the employee requests coverage under the employer's group health plan no later than 60 days after the date of termination of the coverage described in Subsection (2)(a).

(3) Subsection (1) applies if:

(a) the employee or dependent becomes eligible for assistance, with respect to coverage under the employer's group health plan under a plan described in Subsection (2)(a), including under a waiver or demonstration project conducted under or in relation to a plan described in Subsection (2)(a); and

(b) the employee requests coverage under the employer's group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for the assistance described in Subsection (3)(a).

Enacted by Chapter 10, 2010 General Session

31A-22-726 Abortion coverage restriction in health benefit plan and on health insurance exchange.

(1) As used in this section, "permitted abortion coverage" means coverage for abortion:
  (a) that is necessary to avert:
    (i) the death of the woman on whom the abortion is performed; or
    (ii) a serious risk of substantial and irreversible impairment of a major bodily function of the woman on whom the abortion is performed;
  (b) of a fetus that has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal; or
  (c) where the woman is pregnant as a result of:
    (i) rape, as described in Section 76-5-402;
    (ii) rape of a child, as described in Section 76-5-402.1; or
    (iii) incest, as described in Subsection 76-5-406(10) or Section 76-7-102.
(2) A person may not offer coverage for an abortion in a health benefit plan, unless the coverage is a type of permitted abortion coverage.
(3) A person may not offer a health benefit plan that provides coverage for an abortion in a health insurance exchange created under Title 63N, Chapter 11, Health System Reform Act, unless the coverage is a type of permitted abortion coverage.
(4) A person may not offer a health benefit plan that provides coverage for an abortion in a health insurance exchange created under the federal Patient Protection and Affordable Care Act, 111 P.L. 148, unless the coverage is a type of permitted abortion coverage.

Amended by Chapter 283, 2015 General Session