

**Representative James A. Dunnigan** proposes the following substitute bill:

**HEALTH REFORM AMENDMENTS**

2014 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: James A. Dunnigan**

Senate Sponsor: Allen M. Christensen

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**LONG TITLE**

**General Description:**

This bill amends provisions related to health insurance and state and federal health care reform.

**Highlighted Provisions:**

This bill:

- ▶ amends the period of time in which an employee of a state contractor must be enrolled in health insurance to conform to federal law;
- ▶ instructs the Department of Health to:
  - work with the Legislature's Health Reform Task Force to develop a Section 1332 Medicaid waiver; and
  - submit an amendment of the Utah Premium Partnership and Primary Care Network waiver to the Centers for Medicare and Medicaid Services to incorporate the Access Utah program.
- ▶ amends the Utah Health Data Authority Act to facilitate:
  - the coordination of eligibility for health insurance benefits; and
  - cost and quality reports for episodes of care;
- ▶ amends the health insurance navigator license chapter of the Insurance Code to:
  - create two types of navigator licenses;



- 26           • establish different training for the types of licenses; and
- 27           • add an exception to the license requirement for Indian health centers;
- 28       ▶ amends the state Comprehensive Health Insurance Pool to:
- 29           • close the pool to new enrollees;
- 30           • pay out claims incurred by enrollees; and
- 31           • close down the business of the pool;
- 32       ▶ permits an enrollee to re-new an insurance plan as long as permitted by federal
- 33 policy;
- 34       ▶ establishes the state option for calculating the cost to the state if the state mandates
- 35 additional benefits to the PPACA essential health benefits;
- 36       ▶ creates the Individual and Small Employer Risk Adjustment Act, which:
- 37           • requires the insurance commissioner to work with stakeholders to develop a
- 38 state based risk adjustment program for the individual and small group market;
- 39           • describes the risk adjustment models the commissioner may consider;
- 40           • requires the commissioner to report to the Legislature before implementing a
- 41 risk adjustment model;
- 42           • authorizes the commissioner to set fees for the operation of the risk adjustment
- 43 program; and
- 44           • establishes an Individual and Small Employer Risk Adjustment Enterprise Fund
- 45 for the operation of the program;
- 46       ▶ requires the Office of Consumer Health Services, which runs the small employer
- 47 health insurance exchange, to provide the form required for the federal small
- 48 employer premium tax credit to small employers who purchase qualified health
- 49 plans; and
- 50       ▶ makes technical and conforming amendments.

51 **Money Appropriated in this Bill:**

52       None

53 **Other Special Clauses:**

54       This bill provides an effective date.

55       This bill coordinates with H.B. 24, Insurance Related Amendments, by providing

56 superseding and substantive amendments.

57 This bill coordinates with H.B. 35, Reauthorization of Utah Health Data Authority Act,  
58 by providing superseding and substantive amendments.

59 **Utah Code Sections Affected:**

60 AMENDS:

61 **17B-2a-818.5**, as last amended by Laws of Utah 2012, Chapter 347

62 **19-1-206**, as last amended by Laws of Utah 2012, Chapter 347

63 **26-33a-106.1**, as last amended by Laws of Utah 2012, Chapter 279

64 **26-33a-106.5**, as last amended by Laws of Utah 2012, Chapter 279

65 **26-33a-109**, as last amended by Laws of Utah 2010, Chapter 68

66 **31A-4-115**, as last amended by Laws of Utah 2002, Chapter 308

67 **31A-8-402.3**, as last amended by Laws of Utah 2004, Chapter 329

68 **31A-22-721**, as last amended by Laws of Utah 2011, Chapter 284

69 **31A-23b-205**, as enacted by Laws of Utah 2013, Chapter 341

70 **31A-23b-206**, as enacted by Laws of Utah 2013, Chapter 341

71 **31A-23b-211**, as enacted by Laws of Utah 2013, Chapter 341

72 **31A-29-106**, as last amended by Laws of Utah 2013, Chapter 319

73 **31A-29-110**, as last amended by Laws of Utah 2012, Chapter 347

74 **31A-29-111**, as last amended by Laws of Utah 2012, Chapters 158 and 347

75 **31A-29-113**, as last amended by Laws of Utah 2013, Chapter 319

76 **31A-29-114**, as last amended by Laws of Utah 2006, Chapter 95

77 **31A-29-115**, as last amended by Laws of Utah 2004, Chapter 2

78 **31A-30-103**, as last amended by Laws of Utah 2013, Chapter 168

79 **31A-30-107**, as last amended by Laws of Utah 2009, Chapter 12

80 **31A-30-108**, as last amended by Laws of Utah 2011, Chapter 284

81 **31A-30-117**, as enacted by Laws of Utah 2013, Chapter 341

82 **63A-5-205**, as last amended by Laws of Utah 2012, Chapter 347

83 **63C-9-403**, as last amended by Laws of Utah 2012, Chapter 347

84 **63I-1-231 (Effective 07/01/14)**, as last amended by Laws of Utah 2013, Chapters 261

85 and 417

86 **63M-1-2504**, as last amended by Laws of Utah 2013, Chapter 255

87 **72-6-107.5**, as last amended by Laws of Utah 2012, Chapter 347

88 79-2-404, as last amended by Laws of Utah 2012, Chapter 347

89 ENACTS:

90 31A-23b-202.5, Utah Code Annotated 1953

91 31A-30-118, Utah Code Annotated 1953

92 31A-30-301, Utah Code Annotated 1953

93 31A-30-302, Utah Code Annotated 1953

94 31A-30-303, Utah Code Annotated 1953

95 **Utah Code Sections Affected by Coordination Clause:**

96 26-33a-106.1, as last amended by Laws of Utah 2012, Chapter 279

97 31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341

98 31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341



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

101 Section 1. Section 17B-2a-818.5 is amended to read:

102 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**  
103 **coverage.**

104 (1) For purposes of this section:

105 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
106 34A-2-104 who:

107 (i) works at least 30 hours per calendar week; and

108 (ii) meets employer eligibility waiting requirements for health care insurance which  
109 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of  
110 hire.

111 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

112 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

113 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

114 (2) (a) Except as provided in Subsection (3), this section applies to a design or  
115 construction contract entered into by the public transit district on or after July 1, 2009, and to a  
116 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

117 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
118 amount of \$1,500,000 or greater.

119 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
120 \$750,000 or greater.

121 (3) This section does not apply if:

122 (a) the application of this section jeopardizes the receipt of federal funds;

123 (b) the contract is a sole source contract; or

124 (c) the contract is an emergency procurement.

125 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),  
126 or a modification to a contract, when the contract does not meet the initial threshold required  
127 by Subsection (2).

128 (b) A person who intentionally uses change orders or contract modifications to  
129 circumvent the requirements of Subsection (2) is guilty of an infraction.

130 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit  
131 district that the contractor has and will maintain an offer of qualified health insurance coverage  
132 for the contractor's employees and the employee's dependents during the duration of the  
133 contract.

134 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor  
135 shall demonstrate to the public transit district that the subcontractor has and will maintain an  
136 offer of qualified health insurance coverage for the subcontractor's employees and the  
137 employee's dependents during the duration of the contract.

138 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during  
139 the duration of the contract is subject to penalties in accordance with an ordinance adopted by  
140 the public transit district under Subsection (6).

141 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
142 requirements of Subsection (5)(b).

143 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
144 the duration of the contract is subject to penalties in accordance with an ordinance adopted by  
145 the public transit district under Subsection (6).

146 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
147 requirements of Subsection (5)(a).

148 (6) The public transit district shall adopt ordinances:

149 (a) in coordination with:

- 150 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
- 151 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
- 152 (iii) the State Building Board in accordance with Section 63A-5-205;
- 153 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and
- 154 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

155 (b) which establish:

156 (i) the requirements and procedures a contractor shall follow to demonstrate to the  
157 public transit district compliance with this section which shall include:

158 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or  
159 (b) more than twice in any 12-month period; and

160 (B) that the actuarially equivalent determination required for the qualified health  
161 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the  
162 department or division with a written statement of actuarial equivalency from either:

163 (I) the Utah Insurance Department;

164 (II) an actuary selected by the contractor or the contractor's insurer; or

165 (III) an underwriter who is responsible for developing the employer group's premium  
166 rates;

167 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
168 violates the provisions of this section, which may include:

169 (A) a three-month suspension of the contractor or subcontractor from entering into  
170 future contracts with the public transit district upon the first violation;

171 (B) a six-month suspension of the contractor or subcontractor from entering into future  
172 contracts with the public transit district upon the second violation;

173 (C) an action for debarment of the contractor or subcontractor in accordance with  
174 Section 63G-6a-904 upon the third or subsequent violation; and

175 (D) monetary penalties which may not exceed 50% of the amount necessary to  
176 purchase qualified health insurance coverage for employees and dependents of employees of  
177 the contractor or subcontractor who were not offered qualified health insurance coverage  
178 during the duration of the contract; and

179 (iii) a website on which the district shall post the benchmark for the qualified health  
180 insurance coverage identified in Subsection (1)(c).

181 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor  
182 or subcontractor who intentionally violates the provisions of this section shall be liable to the  
183 employee for health care costs that would have been covered by qualified health insurance  
184 coverage.

185 (ii) An employer has an affirmative defense to a cause of action under Subsection  
186 (7)(a)(i) if:

187 (A) the employer relied in good faith on a written statement of actuarial equivalency  
188 provided by an:

189 (I) actuary; or

190 (II) underwriter who is responsible for developing the employer group's premium rates;

191 or

192 (B) a department or division determines that compliance with this section is not  
193 required under the provisions of Subsection (3) or (4).

194 (b) An employee has a private right of action only against the employee's employer to  
195 enforce the provisions of this Subsection (7).

196 (8) Any penalties imposed and collected under this section shall be deposited into the  
197 Medicaid Restricted Account created in Section [26-18-402](#).

198 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
199 coverage as required by this section:

200 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
201 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah  
202 Procurement Code; and

203 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
204 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
205 or construction.

206 Section 2. Section **19-1-206** is amended to read:

207 **19-1-206. Contracting powers of department -- Health insurance coverage.**

208 (1) For purposes of this section:

209 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
210 [34A-2-104](#) who:

211 (i) works at least 30 hours per calendar week; and

212 (ii) meets employer eligibility waiting requirements for health care insurance which  
213 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of  
214 hire.

215 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

216 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

217 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

218 (2) (a) Except as provided in Subsection (3), this section applies to a design or  
219 construction contract entered into by or delegated to the department or a division or board of  
220 the department on or after July 1, 2009, and to a prime contractor or subcontractor in  
221 accordance with Subsection (2)(b).

222 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
223 amount of \$1,500,000 or greater.

224 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
225 \$750,000 or greater.

226 (3) This section does not apply to contracts entered into by the department or a division  
227 or board of the department if:

228 (a) the application of this section jeopardizes the receipt of federal funds;

229 (b) the contract or agreement is between:

230 (i) the department or a division or board of the department; and

231 (ii) (A) another agency of the state;

232 (B) the federal government;

233 (C) another state;

234 (D) an interstate agency;

235 (E) a political subdivision of this state; or

236 (F) a political subdivision of another state;

237 (c) the executive director determines that applying the requirements of this section to a  
238 particular contract interferes with the effective response to an immediate health and safety  
239 threat from the environment; or

240 (d) the contract is:

241 (i) a sole source contract; or

242 (ii) an emergency procurement.



243 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),  
244 or a modification to a contract, when the contract does not meet the initial threshold required  
245 by Subsection (2).

246 (b) A person who intentionally uses change orders or contract modifications to  
247 circumvent the requirements of Subsection (2) is guilty of an infraction.

248 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive  
249 director that the contractor has and will maintain an offer of qualified health insurance  
250 coverage for the contractor's employees and the employees' dependents during the duration of  
251 the contract.

252 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall  
253 demonstrate to the executive director that the subcontractor has and will maintain an offer of  
254 qualified health insurance coverage for the subcontractor's employees and the employees'  
255 dependents during the duration of the contract.

256 (c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration  
257 of the contract is subject to penalties in accordance with administrative rules adopted by the  
258 department under Subsection (6).

259 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
260 requirements of Subsection (5)(b).

261 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
262 the duration of the contract is subject to penalties in accordance with administrative rules  
263 adopted by the department under Subsection (6).

264 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
265 requirements of Subsection (5)(a).

266 (6) The department shall adopt administrative rules:

267 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

268 (b) in coordination with:

269 (i) a public transit district in accordance with Section [17B-2a-818.5](#);

270 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

271 (iii) the State Building Board in accordance with Section [63A-5-205](#);

272 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

273 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

274 (vi) the Legislature's Administrative Rules Review Committee; and  
275 (c) which establish:  
276 (i) the requirements and procedures a contractor shall follow to demonstrate to the  
277 public transit district compliance with this section that shall include:  
278 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or  
279 (b) more than twice in any 12-month period; and  
280 (B) that the actuarially equivalent determination required for the qualified health  
281 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the  
282 department or division with a written statement of actuarial equivalency from either:  
283 (I) the Utah Insurance Department;  
284 (II) an actuary selected by the contractor or the contractor's insurer; or  
285 (III) an underwriter who is responsible for developing the employer group's premium  
286 rates;  
287 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
288 violates the provisions of this section, which may include:  
289 (A) a three-month suspension of the contractor or subcontractor from entering into  
290 future contracts with the state upon the first violation;  
291 (B) a six-month suspension of the contractor or subcontractor from entering into future  
292 contracts with the state upon the second violation;  
293 (C) an action for debarment of the contractor or subcontractor in accordance with  
294 Section [63G-6a-904](#) upon the third or subsequent violation; and  
295 (D) notwithstanding Section [19-1-303](#), monetary penalties which may not exceed 50%  
296 of the amount necessary to purchase qualified health insurance coverage for an employee and  
297 the dependents of an employee of the contractor or subcontractor who was not offered qualified  
298 health insurance coverage during the duration of the contract; and  
299 (iii) a website on which the department shall post the benchmark for the qualified  
300 health insurance coverage identified in Subsection (1)(c).  
301 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or  
302 subcontractor who intentionally violates the provisions of this section shall be liable to the  
303 employee for health care costs that would have been covered by qualified health insurance  
304 coverage.

305 (ii) An employer has an affirmative defense to a cause of action under Subsection  
306 (7)(a)(i) if:

307 (A) the employer relied in good faith on a written statement of actuarial equivalency  
308 provided by:

309 (I) an actuary; or

310 (II) an underwriter who is responsible for developing the employer group's premium  
311 rates; or

312 (B) the department determines that compliance with this section is not required under  
313 the provisions of Subsection (3) or (4).

314 (b) An employee has a private right of action only against the employee's employer to  
315 enforce the provisions of this Subsection (7).

316 (8) Any penalties imposed and collected under this section shall be deposited into the  
317 Medicaid Restricted Account created in Section 26-18-402.

318 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
319 coverage as required by this section:

320 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
321 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah  
322 Procurement Code; and

323 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
324 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
325 or construction.

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

327 **26-33a-106.1. Health care cost and reimbursement data.**

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

331 ~~[(b) The advisory panel shall include:]~~

332 ~~[(i) the chairman of the Utah Hospital Association;]~~

333 ~~[(ii) a representative of a rural hospital as designated by the Utah Hospital~~  
334 ~~Association;]~~

335 ~~[(iii) a representative of the Utah Medical Association;]~~

336 ~~[(iv) a physician from a small group practice as designated by the Utah Medical~~  
337 ~~Association;]~~

338 ~~[(v) two representatives who are health insurers, appointed by the committee;]~~

339 ~~[(vi) a representative from the Department of Health as designated by the executive~~  
340 ~~director of the department;]~~

341 ~~[(vii) a representative from the committee;]~~

342 ~~[(viii) a consumer advocate appointed by the committee;]~~

343 ~~[(ix) a member of the House of Representatives appointed by the speaker of the House;~~  
344 ~~and]~~

345 ~~[(x) a member of the Senate appointed by the president of the Senate.]~~

346 ~~[(c) The advisory panel shall elect a chair from among its members, and shall be~~  
347 ~~staffed by the committee.]~~

348 ~~[(2)(a)] (1) The committee shall, as funding is available:~~

349 ~~[(i)] (a) establish a plan for collecting data from data suppliers, as defined in Section~~  
350 ~~26-33a-102, to determine measurements of cost and reimbursements for risk-adjusted episodes~~  
351 ~~of health care;~~

352 ~~[(ii)] (b) share data regarding insurance claims and an individual's and small employer~~  
353 ~~group's health risk factor and characteristics of insurance arrangements that affect claims and~~  
354 ~~usage with [insurers participating in the defined contribution market created in Title 31A,~~  
355 ~~Chapter 30, Part 2, Defined Contribution Arrangements] the Insurance Department, only to the~~  
356 ~~extent necessary for:~~

357 ~~(i) risk adjusting; and~~

358 ~~(ii) the review and analysis of health insurers' premiums and rate filings; and~~

359 ~~[(A) establishing rates and prospective risk adjusting in the defined contribution~~  
360 ~~arrangement market; and]~~

361 ~~[(B) risk adjusting in the defined contribution arrangement market; and]~~

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

364 ~~[(A)] (i) geographic variances in medical care and costs as demonstrated by data~~  
365 ~~available to the committee; and~~

366 ~~[(B)] (ii) rate and price increases by health care providers:~~

367            ~~[(f)]~~ (A) that exceed the Consumer Price Index - Medical as provided by the United  
 368 States Bureau of Labor Statistics;  
 369            ~~[(H)]~~ (B) as calculated yearly from June to June; and  
 370            ~~[(HH)]~~ (C) as demonstrated by data available to the committee~~[-]~~; and  
 371            (d) provided on at least a monthly basis, enrollment data collected by the committee to  
 372 a not-for-profit, broad-based coalition of state health care insurers and health care providers  
 373 that are involved in the standardized electronic exchange of health data as described in Section  
 374 31A-22-614.5, to the extent necessary:

375            (A) for the department or the Medicaid Office of the Inspector General to determine  
 376 insurance enrollment of an individual for the purpose of determining Medicaid third part  
 377 liability;

378            (B) for an insurer that is a data supplier, to determine insurance enrollment of an  
 379 individual for the purpose of coordination of health care benefits; and

380            (C) for a health care provider, to determine insurance enrollment for a patient for the  
 381 purpose of claims submission by the health care provider.

382            (2) (a) The Medicaid Office of Inspector General shall annually report to the  
 383 Legislature's Health and Human Services Interim Committee regarding how the office used the  
 384 data obtained under Subsection (1)(c)(iii) and the results of obtaining the data.

385            (b) A data supplier shall not be liable for a breach of or unlawful disclosure of the data  
 386 obtained by an entity described in Subsection (1)(c)(iii).

387            ~~[(b)]~~ (3) The plan adopted under ~~[this]~~ Subsection ~~[(2)]~~ (1) shall include:

388            ~~[(+)]~~ (a) the type of data that will be collected;

389            ~~[(ii)]~~ (b) how the data will be evaluated;

390            ~~[(iii)]~~ (c) how the data will be used;

391            ~~[(iv)]~~ (d) the extent to which, and how the data will be protected; and

392            ~~[(v)]~~ (e) who will have access to the data.

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

394            **26-33a-106.5. Comparative analyses.**

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

398 (2) (a) [~~The~~] Except as provided in Subsection (7)(c), the committee shall publish  
399 compilations or reports from the data it collects under this chapter or from any other source  
400 which:

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

402 (ii) compare and identify by name at least a majority of the health care facilities, health  
403 care plans, and institutions in the state.

404 (b) [~~The~~] Except as provided in Subsection (7)(c), the report required by this  
405 Subsection (2) shall:

406 (i) be published at least annually; and

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

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

409 (B) charges; and

410 (C) nationally recognized patient safety standards.

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

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

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

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

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

424 (6) (a) The department shall include in the report required by Subsection (2)(b), or  
425 include in a separate report, comparative information on commonly recognized or generally  
426 agreed upon measures of cost and quality identified in accordance with Subsection (7), for:

427 (i) routine and preventive care; and

428 (ii) the treatment of diabetes, heart disease, and other illnesses or conditions as

429 determined by the committee.

430 (b) The comparative information required by Subsection (6)(a) shall be based on data  
431 collected under Subsection (2) and clinical data that may be available to the committee, and  
432 shall [~~beginning on or after July 1, 2012,~~] compare:

433 (i) beginning December 31, 2014, results for health care facilities or institutions;

434 (ii) beginning December 31, 2014, results for health care providers by geographic  
435 regions of the state;

436 [(~~iii~~)] (iii) beginning July 1, 2016, a clinic's aggregate results for a physician who  
437 practices at a clinic with five or more physicians; and

438 [(~~iii~~)] (iv) beginning July 1, 2016, a geographic region's aggregate results for a  
439 physician who practices at a clinic with less than five physicians, unless the physician requests  
440 physician-level data to be published on a clinic level.

441 (c) The department:

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

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

446 (iii) shall identify and report to the Legislature's Health and Human Services Interim  
447 Committee by July 1, [~~2012~~] 2014, and every July 1[~~;~~] thereafter until July 1, [~~2015, at least~~  
448 ~~five~~] 2019, at least three new measures of quality to be added to the report each year.

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

450 (i) is subject to the requirements of Section [26-33a-107](#); and

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

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

458 (b) If the entity described in Subsection (7)(a) does not submit the quality measures,  
459 the department may select the appropriate number of quality measures for purposes of the

460 report required by Subsection (6).

461 (c) (i) For purposes of the reports published on or after July 1, [~~2012~~] 2014, the  
462 department may not compare individual facilities or clinics as described in Subsections  
463 (6)(b)(i) through [~~(iii)~~] (iv) if the department determines that the data available to the  
464 department can not be appropriately validated, does not represent nationally recognized  
465 measures, does not reflect the mix of cases seen at a clinic or facility, or is not sufficient for the  
466 purposes of comparing providers.

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

469 Section 5. Section **26-33a-109** is amended to read:

470 **26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.**

471 (1) The committee may not disclose any identifiable health data unless:

472 (a) the individual has authorized the disclosure; or

473 (b) the disclosure complies with the provisions of:

474 (i) this section[-];

475 (ii) insurance enrollment and coordination of benefits under Subsection

476 26-33a-104(1)(b); or

477 (iii) risk adjusting under Subsection 26-33a-106.1(1)(c)(iii).

478 (2) The committee shall consider the following when responding to a request for  
479 disclosure of information that may include identifiable health data:

480 (a) whether the request comes from a person after that person has received approval to  
481 do the specific research and statistical work from an institutional review board; and

482 (b) whether the requesting entity complies with the provisions of Subsection (3).

483 (3) A request for disclosure of information that may include identifiable health data  
484 shall:

485 (a) be for a specified period; or

486 (b) be solely for bona fide research and statistical purposes as determined in  
487 accordance with administrative rules adopted by the department, which shall require:

488 (i) the requesting entity to demonstrate to the department that the data is required for  
489 the research and statistical purposes proposed by the requesting entity; and

490 (ii) the requesting entity to enter into a written agreement satisfactory to the department



491 to protect the data in accordance with this chapter or other applicable law.

492 (4) A person accessing identifiable health data pursuant to Subsection (3) may not  
493 further disclose the identifiable health data:

494 (a) without prior approval of the department; and

495 (b) unless the identifiable health data is disclosed or identified by control number only.

496 Section 6. Section **31A-4-115** is amended to read:

497 **31A-4-115. Plan of orderly withdrawal.**

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

501 (b) For purposes of this section, a discontinuance of a health benefit plan pursuant to  
502 one of the following provisions is a withdrawal from a line of insurance:

503 (i) Subsection [31A-30-107\(3\)\(e\)](#); or

504 (ii) Subsection [31A-30-107.1\(3\)\(e\)](#).

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

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

507 (b) include provisions for:

508 (i) meeting the insurer's contractual obligations;

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

510 (iii) meeting any applicable statutory obligations; and

511 (iv) (A) the payment of a withdrawal fee of \$50,000 to the Utah Comprehensive Health  
512 Insurance Pool if:

513 (I) the insurer is an accident and health insurer; and

514 (II) the insurer's line of business is not assumed or placed with another insurer

515 approved by the commissioner; or

516 (B) the payment of a withdrawal fee of \$50,000 to the department if:

517 (I) the insurer is not an accident and health insurer; and

518 (II) the insurer's line of business is not assumed or placed with another insurer

519 approved by the commissioner.

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

- 522 (a) protect the interests of the people of the state;
- 523 (b) meet the insurer's contractual obligations;
- 524 (c) provide service to the insurer's Utah policyholders and claimants; and
- 525 (d) meet any applicable statutory obligations.

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

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

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

533 (b) the insurer:

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

535 (ii) intends to:

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

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

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

539 (a) withdraws from writing insurance in this state; or

540 (b) reduces its total annual premium volume by 75% or more in any year without  
 541 having submitted a plan or receiving the commissioner's approval.

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

545 ~~[(i)]~~ (a) in the public interest to promote competition; or

546 ~~[(ii)]~~ (b) to resolve inequity in the marketplace~~[-and]~~.

547 ~~[(b) the insurer complies with Subsection 31A-30-108(5), if applicable.]~~

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

549 Section 7. Section 31A-8-402.3 is amended to read:

550 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**  
 551 **plans.**

552 (1) Except as otherwise provided in this section, a group health benefit plan for a plan

553 sponsor is renewable and continues in force:

554 (a) with respect to all eligible employees and dependents; and

555 (b) at the option of the plan sponsor.

556 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed~~[(a)]~~

557 for a network plan, if:

558 ~~[(i)]~~ (a) there is no longer any enrollee under the group health plan who lives, resides,

559 or works in:

560 ~~[(A)]~~ (i) the service area of the insurer; or

561 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and] or~~

562 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~

563 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]~~

564 (b) for coverage made available in the small or large employer market only through an

565 association, if:

566 (i) the employer's membership in the association ceases; and

567 (ii) the coverage is terminated uniformly without regard to any health status-related

568 factor relating to any covered individual.

569 (3) A health benefit plan for a plan sponsor may be discontinued if:

570 (a) a condition described in Subsection (2) exists;

571 (b) the plan sponsor fails to pay premiums or contributions in accordance with the

572 terms of the contract;

573 (c) the plan sponsor:

574 (i) performs an act or practice that constitutes fraud; or

575 (ii) makes an intentional misrepresentation of material fact under the terms of the

576 coverage;

577 (d) the insurer:

578 (i) elects to discontinue offering a particular health benefit product delivered or issued

579 for delivery in this state; and

580 (ii) (A) provides notice of the discontinuation in writing:

581 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

582 (II) at least 90 days before the date the coverage will be discontinued;

583 (B) provides notice of the discontinuation in writing:

- 584 (I) to the commissioner; and
- 585 (II) at least three working days prior to the date the notice is sent to the affected plan
- 586 sponsors, employees, and dependents of the plan sponsors or employees;
- 587 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
- 588 (I) all other health benefit products currently being offered by the insurer in the market;
- 589 or
- 590 (II) in the case of a large employer, any other health benefit product currently being
- 591 offered in that market; and
- 592 (D) in exercising the option to discontinue that product and in offering the option of
- 593 coverage in this section, acts uniformly without regard to:
- 594 (I) the claims experience of a plan sponsor;
- 595 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 596 (III) any health status-related factor relating to any new participant or beneficiary who
- 597 may become eligible for the coverage; or
- 598 (e) the insurer:
- 599 (i) elects to discontinue all of the insurer's health benefit plans in:
- 600 (A) the small employer market;
- 601 (B) the large employer market; or
- 602 (C) both the small employer and large employer markets; and
- 603 (ii) (A) provides notice of the discontinuation in writing:
- 604 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 605 (II) at least 180 days before the date the coverage will be discontinued;
- 606 (B) provides notice of the discontinuation in writing:
- 607 (I) to the commissioner in each state in which an affected insured individual is known
- 608 to reside; and
- 609 (II) at least 30 working days prior to the date the notice is sent to the affected plan
- 610 sponsors, employees, and the dependents of the plan sponsors or employees;
- 611 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 612 market; and
- 613 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 614 (4) A large employer health benefit plan may be discontinued or nonrenewed:

- 615 (a) if a condition described in Subsection (2) exists; or
- 616 (b) for noncompliance with the insurer's:
  - 617 (i) minimum participation requirements; or
  - 618 (ii) employer contribution requirements.
- 619 (5) A small employer health benefit plan may be discontinued or nonrenewed:
  - 620 (a) if a condition described in Subsection (2) exists; or
  - 621 (b) for noncompliance with the insurer's employer contribution requirements.
- 622 (6) A small employer health benefit plan may be nonrenewed:
  - 623 (a) if a condition described in Subsection (2) exists; or
  - 624 (b) for noncompliance with the insurer's minimum participation requirements.
- 625 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 626 discontinued if after issuance of coverage the eligible employee:
  - 627 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
  - 628 or
  - 629 (ii) makes an intentional misrepresentation of material fact in connection with the
  - 630 coverage.
- 631 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
  - 632 (i) 12 months after the date of discontinuance; and
  - 633 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
  - 634 to reenroll.
- 635 (c) At the time the eligible employee's coverage is discontinued under Subsection
- 636 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
- 637 discontinued.
- 638 (d) An eligible employee may not be discontinued under this Subsection (7) because of
- 639 a fraud or misrepresentation that relates to health status.
- 640 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
- 641 the employer:
  - 642 (a) with respect to coverage provided to an employer member of the association; and
  - 643 (b) if the health benefit plan is made available by an insurer in the employer market
  - 644 only through:
    - 645 (i) an association;

- 646 (ii) a trust; or
- 647 (iii) a discretionary group.
- 648 (9) An insurer may modify a health benefit plan for a plan sponsor only:
- 649 (a) at the time of coverage renewal; and
- 650 (b) if the modification is effective uniformly among all plans with that product.

651 Section 8. Section **31A-22-721** is amended to read:

652 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**  
653 **nonrenewal.**

654 (1) Except as otherwise provided in this section, a health benefit plan for a plan  
655 sponsor is renewable and continues in force:

- 656 (a) with respect to all eligible employees and dependents; and
- 657 (b) at the option of the plan sponsor.

658 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed~~[(a)]~~  
659 for a network plan, if:

660 ~~[(i)]~~ (a) there is no longer any enrollee under the group health plan who lives, resides,  
661 or works in:

662 ~~[(A)]~~ (i) the service area of the insurer; or

663 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and]~~ or

664 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~  
665 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7), or]~~

666 (b) for coverage made available in the small or large employer market only through an  
667 association, if:

668 (i) the employer's membership in the association ceases; and

669 (ii) the coverage is terminated uniformly without regard to any health status-related  
670 factor relating to any covered individual.

671 (3) A health benefit plan for a plan sponsor may be discontinued if:

672 (a) a condition described in Subsection (2) exists;

673 (b) the plan sponsor fails to pay premiums or contributions in accordance with the  
674 terms of the contract;

675 (c) the plan sponsor:

676 (i) performs an act or practice that constitutes fraud; or

677 (ii) makes an intentional misrepresentation of material fact under the terms of the  
678 coverage;

679 (d) the insurer:

680 (i) elects to discontinue offering a particular health benefit product delivered or issued  
681 for delivery in this state;

682 (ii) (A) provides notice of the discontinuation in writing:

683 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and  
684 (II) at least 90 days before the date the coverage will be discontinued;

685 (B) provides notice of the discontinuation in writing:

686 (I) to the commissioner; and  
687 (II) at least three working days prior to the date the notice is sent to the affected plan  
688 sponsors, employees, and dependents of plan sponsors or employees;

689 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any  
690 other health benefit products currently being offered:

691 (I) by the insurer in the market; or  
692 (II) in the case of a large employer, any other health benefit plan currently being  
693 offered in that market; and

694 (D) in exercising the option to discontinue that product and in offering the option of  
695 coverage in this section, the insurer acts uniformly without regard to:

696 (I) the claims experience of a plan sponsor;  
697 (II) any health status-related factor relating to any covered participant or beneficiary; or  
698 (III) any health status-related factor relating to a new participant or beneficiary who  
699 may become eligible for coverage; or

700 (e) the insurer:

701 (i) elects to discontinue all of the insurer's health benefit plans:

702 (A) in the small employer market; or  
703 (B) the large employer market; or  
704 (C) both the small and large employer markets; and

705 (ii) (A) provides notice of the discontinuance in writing:

706 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and  
707 (II) at least 180 days before the date the coverage will be discontinued;

- 708 (B) provides notice of the discontinuation in writing:
- 709 (I) to the commissioner in each state in which an affected insured individual is known  
710 to reside; and
- 711 (II) at least 30 business days prior to the date the notice is sent to the affected plan  
712 sponsors, employees, and dependents of a plan sponsor or employee;
- 713 (C) discontinues and nonrenews all plans issued or delivered for issuance in the  
714 market; and
- 715 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
- 716 (4) A large employer health benefit plan may be discontinued or nonrenewed:
- 717 (a) if a condition described in Subsection (2) exists; or
- 718 (b) for noncompliance with the insurer's:
- 719 (i) minimum participation requirements; or
- 720 (ii) employer contribution requirements.
- 721 (5) A small employer health benefit plan may be discontinued or nonrenewed:
- 722 (a) if a condition described in Subsection (2) exists; or
- 723 (b) for noncompliance with the insurer's employer contribution requirements.
- 724 (6) A small employer health benefit plan may be nonrenewed:
- 725 (a) if a condition described in Subsection (2) exists; or
- 726 (b) for noncompliance with the insurer's minimum participation requirements.
- 727 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be  
728 discontinued if after issuance of coverage the eligible employee:
- 729 (i) engages in an act or practice that constitutes fraud in connection with the coverage;  
730 or
- 731 (ii) makes an intentional misrepresentation of material fact in connection with the  
732 coverage.
- 733 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
- 734 (i) 12 months after the date of discontinuance; and
- 735 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
736 to reenroll.
- 737 (c) At the time the eligible employee's coverage is discontinued under Subsection  
738 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is



739 discontinued.

740 (d) An eligible employee may not be discontinued under this Subsection (7) because of  
741 a fraud or misrepresentation that relates to health status.

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

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

748 (i) to promote competition; or

749 (ii) to resolve inequity in the marketplace.

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

752 (10) An insurer may modify a health benefit plan for a plan sponsor only:

753 (a) at the time of coverage renewal; and

754 (b) if the modification is effective uniformly among all plans with a particular product  
755 or service.

756 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to  
757 the employer:

758 (a) with respect to coverage provided to an employer member of the association; and

759 (b) if the health benefit plan is made available by an insurer in the employer market  
760 only through:

761 (i) an association;

762 (ii) a trust; or

763 (iii) a discretionary group.

764 (12) (a) A small employer that, after purchasing a health benefit plan in the small group  
765 market, employs on average more than 50 eligible employees on each business day in a  
766 calendar year may continue to renew the health benefit plan purchased in the small group  
767 market.

768 (b) A large employer that, after purchasing a health benefit plan in the large group  
769 market, employs on average less than 51 eligible employees on each business day in a calendar

770 year may continue to renew the health benefit plan purchased in the large group market.

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

773 Section 9. Section **31A-23b-202.5** is enacted to read:

774 **31A-23b-202.5. License types.**

775 (1) A license issued under this chapter shall be issued under the license types described  
776 in Subsection (2).

777 (2) A license type under this chapter shall be a navigator line of authority or a certified  
778 application counselor line of authority. A license type is intended to describe the matters to be  
779 considered under any education, examination, and training required of an applicant under this  
780 chapter.

781 (3) (a) A navigator line of authority includes the enrollment process as described in  
782 Subsection [31A-23b-102\(4\)\(a\)](#).

783 (b) (i) A certified application counselor line of authority is limited to providing  
784 information and assistance to individuals and employees about public programs and premium  
785 subsidies available through the exchange.

786 (ii) A certified application counselor line of authority does not allow the certified  
787 application counselor to assist a person with the selection of or enrollment in a qualified health  
788 plan offered on an exchange.

789 Section 10. Section **31A-23b-205** is amended to read:

790 **31A-23b-205. Examination and training requirements.**

791 (1) The commissioner may require [~~applicants~~] an applicant for a license to pass an  
792 examination and complete a training program as a requirement for a license.

793 (2) The examination described in Subsection (1) shall reasonably relate to:

794 (a) the duties and functions of a navigator;

795 (b) requirements for navigators as established by federal regulation under PPACA; and

796 (c) other requirements that may be established by the commissioner by administrative  
797 rule.

798 (3) The examination may be administered by the commissioner or as otherwise  
799 specified by administrative rule.

800 (4) The training required by Subsection (1) shall be approved by the commissioner and

801 shall include:

- 802 (a) accident and health insurance plans;
- 803 (b) qualifications for and enrollment in public programs;
- 804 (c) qualifications for and enrollment in premium subsidies;
- 805 (d) cultural and linguistic competence;
- 806 (e) conflict of interest standards;
- 807 (f) exchange functions; and
- 808 (g) other requirements that may be adopted by the commissioner by administrative

809 rule.

810 (5) (a) For the navigator line of authority, the training required by Subsection (1) shall  
811 consist of at least 21 credit hours of training before obtaining the license, which shall include:

812 (i) at least two hours of training on defined contribution arrangements and the small  
813 employer health insurance exchange; and

814 (ii) the navigator training and certification program developed by the Centers for  
815 Medicare and Medicaid Services.

816 (b) For the certified application counselor line of authority, the training required by  
817 Subsection (1) shall consist of at least six hours of training before obtaining a license, which  
818 shall include:

819 (i) at least one hour of training on defined contribution arrangements and the small  
820 employer health insurance exchange; and

821 (ii) the certified application counselor training and certification program developed by  
822 the Centers for Medicare and Medicaid Services.

823 ~~[(5)]~~ (6) This section applies only to [applicants who are natural persons] an applicant  
824 who is a natural person.

825 Section 11. Section **31A-23b-206** is amended to read:

826 **31A-23b-206. Continuing education requirements.**

827 (1) The commissioner shall, by rule, prescribe continuing education requirements for a  
828 navigator.

829 (2) (a) The commissioner may not require a degree from an institution of higher  
830 education as part of continuing education.

831 (b) The commissioner may state a continuing education requirement in terms of hours

832 of instruction received in:

- 833 (i) accident and health insurance;
- 834 (ii) qualification for and enrollment in public programs;
- 835 (iii) qualification for and enrollment in premium subsidies;
- 836 (iv) cultural competency;
- 837 (v) conflict of interest standards; and
- 838 (vi) other exchange functions.

839 (3) (a) ~~Continuing~~ For a navigator line of authority, continuing education  
840 requirements shall require:

841 (i) that a licensee complete ~~[24]~~ 12 credit hours of continuing education for every  
842 ~~[two-year]~~ one-year licensing period;

843 (ii) that ~~[3]~~ at least two of the ~~[24]~~ 12 credit hours described in Subsection (3)(a)(i) be  
844 ethics courses; ~~[and]~~

845 ~~[(iii) that the licensee complete at least half of the required hours through classroom~~  
846 ~~hours of insurance and exchange related instruction.]~~

847 (iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training  
848 on defined contribution arrangements and the use of the small employer health insurance  
849 exchange; and

850 (iv) that a licensee complete the annual navigator training and certification program  
851 developed by the Centers for Medicare and Medicaid Services.

852 (b) For a certified application counselor, the continuing education requirements shall  
853 require:

854 (i) that a licensee complete six credit hours of continuing education for every one-year  
855 licensing period;

856 (ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on  
857 ethics courses;

858 (iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be training  
859 on defined contribution arrangements and the use of the small employer health insurance  
860 exchange; and

861 (iv) that a licensee complete the annual certified application counselor training and  
862 certification program developed by the Centers for Medicare and Medicaid Services.

863 ~~[(b)]~~ (c) An hour of continuing education in accordance with ~~[Subsection]~~ Subsections

864 (3)(a)(i) ~~and(b)(i)~~ may be obtained through:

865 (i) classroom attendance;

866 (ii) home study;

867 (iii) watching a video recording; or

868 ~~[(iv) experience credit; or]~~

869 ~~[(v)]~~ (iv) another method approved by rule.

870 ~~[(e)]~~ (d) A licensee may obtain continuing education hours at any time during the

871 ~~[two-year]~~ one-year license period.

872 ~~[(d)]~~ (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking

873 Act, the commissioner shall, by rule: ~~(i) publish a list of insurance professional designations~~

874 ~~whose continuing education requirements can be used to meet the requirements for continuing~~

875 ~~education under Subsection (3)(b); and (ii)]~~, authorize one or more continuing education

876 providers, including a state or national professional producer or consultant associations, to:

877 ~~[(A)]~~ (i) offer a qualified program on a geographically accessible basis; and

878 ~~[(B)]~~ (ii) collect a reasonable fee for funding and administration of a continuing

879 education program, subject to the review and approval of the commissioner.

880 (4) The commissioner shall approve a continuing education provider or a continuing

881 education course that satisfies the requirements of this section.

882 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

883 commissioner shall by rule establish the procedures for continuing education provider

884 registration and course approval.

885 (6) This section applies only to a navigator who is a natural person.

886 (7) A navigator shall keep documentation of completing the continuing education

887 requirements of this section for two years after the end of the two-year licensing period to

888 which the continuing education applies.

889 Section 12. Section **31A-23b-211** is amended to read:

890 **31A-23b-211. Exceptions to navigator licensing.**

891 (1) For purposes of this section:

892 (a) "Negotiate" is as defined in Section **31A-23a-102**.

893 (b) "Sell" is as defined in Section **31A-23a-102**.

894 (c) "Solicit" is as defined in Section 31A-23a-102.  
895 (2) The commissioner may not require a license as a navigator of:  
896 (a) a person who is employed by or contracts with:  
897 (i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility  
898 Licensing and Inspection Act, to assist an individual with enrollment in a public program or an  
899 application for premium subsidy; or  
900 (ii) the state, a political subdivision of the state, an entity of a political subdivision of  
901 the state, or a public school district to assist an individual with enrollment in a public program  
902 or an application for premium subsidy;  
903 (b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social  
904 Security Act which assists an individual with enrollment in a public program or an application  
905 for premium subsidy;  
906 (c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants,  
907 and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to  
908 sell, solicit, or negotiate accident and health insurance plans;  
909 (d) an officer, director, or employee of a navigator:  
910 (i) who does not receive compensation or commission from an insurer issuing an  
911 insurance contract, an agency administering a public program, an individual who enrolled in a  
912 public program or insurance product, or an exchange; and  
913 (ii) whose activities:  
914 (A) are executive, administrative, managerial, clerical, or a combination thereof;  
915 (B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the  
916 enrollment in a public program offered through the exchange;  
917 (C) are in the capacity of a special agent or agency supervisor assisting an insurance  
918 producer or navigator;  
919 (D) are limited to providing technical advice and assistance to a licensed insurance  
920 producer or navigator; or  
921 (E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment  
922 in a public program; [~~and~~]  
923 (e) a person who does not sell, solicit, or negotiate insurance and is not directly or  
924 indirectly compensated by an insurer issuing an insurance contract, an agency administering a

925 public program, an individual who enrolled in a public program or insurance product, or an  
 926 exchange, including:

927 (i) an employer, association, officer, director, employee, or trustee of an employee trust  
 928 plan who is engaged in the administration or operation of a program:

929 (A) of employee benefits for the employer's or association's own employees or the  
 930 employees of a subsidiary or affiliate of an employer or association; and

931 (B) that involves the use of insurance issued by an insurer or enrollment in a public  
 932 health plan on an exchange;

933 (ii) an employee of an insurer or organization employed by an insurer who is engaging  
 934 in the inspection, rating, or classification of risk, or the supervision of training of insurance  
 935 producers; or

936 (iii) an employee who counsels or advises the employee's employer with regard to the  
 937 insurance interests of the employer, or a subsidiary or business affiliate of the employer[-]; and

938 (f) an Indian health clinic or Urban Indian Health Center, as defined in Title V of the  
 939 Indian Health Care Improvement Act, which assists a person with enrollment in a public  
 940 program or an application for a premium subsidy.

941 (3) The exemption from licensure under Subsections (2)(a) [~~and~~], (b), and (f) does not  
 942 apply if a person described in Subsections (2)(a) [~~and~~], (b), and (f) enrolls a person in a private  
 943 insurance plan.

944 (4) The commissioner may by rule exempt a class of persons from the license  
 945 requirement of Subsection 31A-23b-201(1) if:

946 (a) the functions performed by the class of persons do not require:

947 (i) special competence;

948 (ii) special trustworthiness; or

949 (iii) regulatory surveillance made possible by licensing; or

950 (b) other existing safeguards make regulation unnecessary.

951 Section 13. Section 31A-29-106 is amended to read:

952 **31A-29-106. Powers of board.**

953 (1) The board shall have the general powers and authority granted under the laws of  
 954 this state to insurance companies licensed to transact health care insurance business. In  
 955 addition, the board shall [~~have the specific authority to~~]:

956 (a) have the specific authority to enter into contracts to carry out the provisions and  
957 purposes of this chapter, including, with the approval of the commissioner, contracts with:  
958 (i) similar pools of other states for the joint performance of common administrative  
959 functions; or  
960 (ii) persons or other organizations for the performance of administrative functions;  
961 (b) sue or be sued, including taking such legal action necessary to avoid the payment of  
962 improper claims against the pool or the coverage provided through the pool;  
963 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,  
964 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the  
965 operation of the pool;  
966 ~~[(d) issue policies of insurance in accordance with the requirements of this chapter;]~~  
967 (d) (i) close enrollment in the plans issued by the pool and cancel the plans issued by  
968 the pool in accordance with the plan of operation approved by the commissioner; and  
969 (ii) close out the business of the pool in accordance with the plan of operation,  
970 including processing and paying valid claims incurred by enrollees prior to the date enrollment  
971 is closed under Subsection (1)(d)(i);  
972 (e) retain an executive director and appropriate legal, actuarial, and other personnel as  
973 necessary to provide technical assistance in the operations of the pool and to close pool  
974 business in accordance with Subsection (1)(d);  
975 (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;  
976 (g) cause the pool to have an annual and a final audit of its operations by the state  
977 auditor;  
978 ~~[(h) coordinate with the Department of Health in seeking to obtain from the Centers for~~  
979 ~~Medicare and Medicaid Services, or other appropriate office or agency of government, all~~  
980 ~~appropriate waivers, authority, and permission needed to coordinate the coverage available~~  
981 ~~from the pool with coverage available under Medicaid, either before or after Medicaid~~  
982 ~~coverage, or as a conversion option upon completion of Medicaid eligibility, without the~~  
983 ~~necessity for requalification by the enrollee;]~~  
984 ~~[(i)]~~ (h) provide for and employ cost containment measures and requirements including  
985 preadmission certification, concurrent inpatient review, and individual case management for  
986 the purpose of making the pool more cost-effective;



987 ~~[(j) offer pool coverage through contracts with health maintenance organizations,~~  
 988 ~~preferred provider organizations, and other managed care systems that will manage costs while~~  
 989 ~~maintaining quality care;]~~

990 ~~[(k) (i) establish annual limits on benefits payable under the pool to or on behalf of~~  
 991 ~~any enrollee;~~

992 ~~[(l) (j) exclude from coverage under the pool specific benefits, medical conditions,~~  
 993 ~~and procedures for the purpose of protecting the financial viability of the pool;~~

994 ~~[(m) (k) administer the Pool Fund;~~

995 ~~[(n) (l) make rules in accordance with Title 63G, Chapter 3, Utah Administrative~~  
 996 ~~Rulemaking Act, to implement this chapter;~~

997 ~~[(o) (m) adopt, trademark, and copyright a trade name for the pool for use in~~  
 998 ~~marketing and publicizing the pool and its products; and~~

999 ~~[(p) (n) transition health care coverage for all individuals covered under the pool as~~  
 1000 ~~part of the conversion to health insurance coverage, regardless of preexisting conditions, under~~  
 1001 ~~PPACA.~~

1002 (2) (a) The board shall prepare and submit an annual and final report to the Legislature  
 1003 which shall include:

1004 (i) the net premiums anticipated;

1005 (ii) actuarial projections of payments required of the pool;

1006 (iii) the expenses of administration; and

1007 (iv) the anticipated reserves or losses of the pool.

1008 (b) The budget for operation of the pool is subject to the approval of the board.

1009 (c) The administrative budget of the board and the commissioner under this chapter  
 1010 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is  
 1011 subject to review and approval by the Legislature.

1012 ~~[(3)(a) The board shall on or before September 1, 2004, require the plan administrator~~  
 1013 ~~or an independent actuarial consultant retained by the plan administrator to redetermine the~~  
 1014 ~~reasonable equivalent of the criteria for uninsurability required under Subsection~~

1015 ~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]~~

1016 ~~[(b) The board shall redetermine the criteria established in Subsection (3)(a) at least~~  
 1017 ~~every five years thereafter.]~~

1018 Section 14. Section 31A-29-110 is amended to read:

1019 **31A-29-110. Pool administrator -- Selection -- Powers.**

1020 (1) The board shall select a pool administrator in accordance with Title 63G, Chapter  
1021 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the  
1022 board, which shall include:

- 1023 (a) ability to manage medical expenses;
- 1024 (b) proven ability to handle accident and health insurance;
- 1025 (c) efficiency of claim paying procedures;
- 1026 (d) marketing and underwriting;
- 1027 (e) proven ability for managed care and quality assurance;
- 1028 (f) provider contracting and discounts;
- 1029 (g) pharmacy benefit management;
- 1030 (h) an estimate of total charges for administering the pool; and
- 1031 (i) ability to administer the pool in a cost-efficient manner.

1032 (2) A pool administrator may be:

- 1033 (a) a health insurer;
- 1034 (b) a health maintenance organization;
- 1035 (c) a third-party administrator; or
- 1036 (d) any person or entity which has demonstrated ability to meet the criteria in

1037 Subsection (1).

1038 (3) ~~[(a)]~~ The pool administrator shall serve for a period of three years, with ~~[two~~  
1039 ~~one-year]~~ yearly extension options until the operations of the pool are closed pursuant to  
1040 Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract  
1041 between the board and the administrator.

1042 ~~[(b) At least one year prior to the expiration of the contract between the board and the~~  
1043 ~~pool administrator, the board shall invite all interested parties, including the current pool~~  
1044 ~~administrator, to submit bids to serve as the pool administrator].~~

1045 ~~[(c) Selection of the pool administrator for a succeeding period shall be made at least~~  
1046 ~~six months prior to the expiration of the period of service under Subsection (3)(a).]~~

1047 (4) The pool administrator is responsible for all operational functions of the pool and  
1048 shall:

1049 (a) have access to all nonpatient specific experience data, statistics, treatment criteria,  
1050 and guidelines compiled or adopted by the Medicaid program, the Public Employees Health  
1051 Plan, the Department of Health, or the Insurance Department, and which are not otherwise  
1052 declared by statute to be confidential;

1053 (b) perform all marketing, eligibility, enrollment, member agreements, and  
1054 administrative claim payment functions relating to the pool;

1055 (c) establish, administer, and operate a monthly premium billing procedure for  
1056 collection of premiums from enrollees;

1057 (d) perform all necessary functions to assure timely payment of benefits to enrollees,  
1058 including:

1059 (i) making information available relating to the proper manner of submitting a claim  
1060 for benefits to the pool administrator and distributing forms upon which submission shall be  
1061 made; and

1062 (ii) evaluating the eligibility of each claim for payment by the pool;

1063 (e) submit regular reports to the board regarding the operation of the pool, the  
1064 frequency, content, and form of which reports shall be determined by the board;

1065 (f) following the close of each calendar year, determine net written and earned  
1066 premiums, the expense of administration, and the paid and incurred losses for the year and  
1067 submit a report of this information to the board, the commissioner, and the Division of Finance  
1068 on a form prescribed by the commissioner; and

1069 (g) be paid as provided in the plan of operation for expenses incurred in the  
1070 performance of the pool administrator's services.

1071 Section 15. Section **31A-29-111** is amended to read:

1072 **31A-29-111. Eligibility -- Limitations.**

1073 (1) (a) Except as provided in Subsection (1)(b) and Subsection [31A-29-106\(1\)\(d\)](#), an  
1074 individual who is not HIPAA eligible is eligible for pool coverage if the individual:

1075 (i) pays the established premium;

1076 (ii) is a resident of this state; and

1077 (iii) meets the health underwriting criteria under Subsection (5)(a).

1078 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not  
1079 eligible for pool coverage if one or more of the following conditions apply:

- 1080 (i) the individual is eligible for health care benefits under Medicaid or Medicare,  
1081 except as provided in Section [31A-29-112](#);
- 1082 (ii) the individual has terminated coverage in the pool, unless:  
1083 (A) 12 months have elapsed since the termination date; or  
1084 (B) the individual demonstrates that creditable coverage has been involuntarily  
1085 terminated for any reason other than nonpayment of premium;
- 1086 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;  
1087 (iv) the individual is an inmate of a public institution;  
1088 (v) the individual is eligible for a public health plan, as defined in federal regulations  
1089 adopted pursuant to 42 U.S.C. 300gg;
- 1090 (vi) the individual's health condition does not meet the criteria established under  
1091 Subsection (5);
- 1092 (vii) the individual is eligible for coverage under an employer group that offers a health  
1093 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members  
1094 as:
- 1095 (A) an eligible employee;  
1096 (B) a dependent of an eligible employee; or  
1097 (C) a member;
- 1098 (viii) the individual is covered under any other health benefit plan;  
1099 (ix) except as provided in Subsections (3) and (6), at the time of application, the  
1100 individual has not resided in Utah for at least 12 consecutive months preceding the date of  
1101 application; or
- 1102 (x) the individual's employer pays any part of the individual's health benefit plan  
1103 premium, either as an insured or a dependent, for pool coverage.
- 1104 (2) (a) Except as provided in Subsection (2)(b) and Subsection [31A-29-106\(1\)\(d\)](#), an  
1105 individual who is HIPAA eligible is eligible for pool coverage if the individual:
- 1106 (i) pays the established premium; and  
1107 (ii) is a resident of this state.
- 1108 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for  
1109 pool coverage if one or more of the following conditions apply:  
1110 (i) the individual is eligible for health care benefits under Medicaid or Medicare,

1111 except as provided in Section 31A-29-112;

1112 (ii) the individual is eligible for a public health plan, as defined in federal regulations  
1113 adopted pursuant to 42 U.S.C. 300gg;

1114 (iii) the individual is covered under any other health benefit plan;

1115 (iv) the individual is eligible for coverage under an employer group that offers a health  
1116 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members  
1117 as:

1118 (A) an eligible employee;

1119 (B) a dependent of an eligible employee; or

1120 (C) a member;

1121 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

1122 (vi) the individual is an inmate of a public institution; or

1123 (vii) the individual's employer pays any part of the individual's health benefit plan  
1124 premium, either as an insured or a dependent, for pool coverage.

1125 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection  
1126 (1)(a), an individual whose health care insurance coverage from a state high risk pool with  
1127 similar coverage is terminated because of nonresidency in another state is eligible for coverage  
1128 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

1129 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the  
1130 termination date of the previous high risk pool coverage.

1131 (c) The effective date of this state's pool coverage shall be the date of termination of  
1132 the previous high risk pool coverage.

1133 (d) The waiting period of an individual with a preexisting condition applying for  
1134 coverage under this chapter shall be waived:

1135 (i) to the extent to which the waiting period was satisfied under a similar plan from  
1136 another state; and

1137 (ii) if the other state's benefit limitation was not reached.

1138 (4) (a) If an eligible individual applies for pool coverage within 30 days of being  
1139 denied coverage by an individual carrier, the effective date for pool coverage shall be no later  
1140 than the first day of the month following the date of submission of the completed insurance  
1141 application to the carrier.

1142 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under  
1143 Subsection (3), the effective date shall be the date of termination of the previous high risk pool  
1144 coverage.

1145 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria  
1146 based on:

1147 (i) health condition; and

1148 (ii) expected claims so that the expected claims are anticipated to remain within  
1149 available funding.

1150 (b) The board, with approval of the commissioner, may contract with one or more  
1151 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting  
1152 criteria under Subsection (5)(a).

1153 (c) If an individual is denied coverage by the pool under the criteria established in  
1154 Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage  
1155 under ~~[Subsection]~~ Section 31A-30-108~~(3)~~.

1156 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection  
1157 (1)(a), an individual whose individual health care insurance coverage was involuntarily  
1158 terminated, is eligible for coverage under the pool subject to the conditions of Subsections  
1159 (1)(b)(i) through (viii) and (x).

1160 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the  
1161 termination date of the previous individual health care insurance coverage.

1162 (c) The effective date of this state's pool coverage shall be the date of termination of  
1163 the previous individual coverage.

1164 (d) The waiting period of an individual with a preexisting condition applying for  
1165 coverage under this chapter shall be waived to the extent to which the waiting period was  
1166 satisfied under the individual health insurance plan.

1167 Section 16. Section **31A-29-113** is amended to read:

1168 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**  
1169 **conditions -- Waiver -- Maximum benefits.**

1170 (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished  
1171 for the diagnoses or treatment of illness or injury that:

1172 (i) exceed the deductible and copayment amounts applicable under Section

1173 31A-29-114; and

1174 (ii) are not otherwise limited or excluded.

1175 (b) Eligible medical expenses are the allowed charges established by the board for the  
1176 health care services and items rendered during times for which benefits are extended under the  
1177 pool policy.

1178 (c) Section 31A-21-313 applies to coverage issued under this chapter.

1179 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and  
1180 other limitations shall be established by the board.

1181 (3) The commissioner shall approve the benefit package developed by the board to  
1182 ensure its compliance with this chapter.

1183 ~~[(4) The pool shall offer at least one benefit plan through a managed care program as~~  
1184 ~~authorized under Section 31A-29-106.]~~

1185 [(5)] (4) This chapter may not be construed to prohibit the pool from issuing additional  
1186 types of pool policies with different types of benefits which in the opinion of the board may be  
1187 of benefit to the citizens of Utah.

1188 [(6)] (5) (a) The board shall design and require an administrator to employ cost  
1189 containment measures and requirements including preadmission certification and concurrent  
1190 inpatient review for the purpose of making the pool more cost effective.

1191 (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this  
1192 chapter.

1193 [(7)] (6) (a) A pool policy may contain provisions under which coverage for a  
1194 preexisting condition is excluded if:

1195 (i) the exclusion relates to a condition, regardless of the cause of the condition, for  
1196 which medical advice, diagnosis, care, or treatment was recommended or received, from an  
1197 individual licensed or similarly authorized to provide such services under state law and  
1198 operating within the scope of practice authorized by state law, within the six-month period  
1199 ending on the effective date of plan coverage; and

1200 (ii) except as provided in Subsection (8), the exclusion extends for a period no longer  
1201 than the six-month period following the effective date of plan coverage for a given individual.

1202 (b) Subsection [(7)] (6)(a) does not apply to a HIPAA eligible individual.

1203 [(8)] (7) (a) A pool policy may contain provisions under which coverage for a

1204 preexisting pregnancy is excluded during a ten-month period following the effective date of  
1205 plan coverage for a given individual.

1206 (b) Subsection [(8)] (7)(a) does not apply to a HIPAA eligible individual.

1207 [(9)] (8) (a) The pool will waive the preexisting condition exclusion described in  
1208 Subsections [(7)] (6)(a) and [(8)] (7)(a) for an individual that is changing health coverage to the  
1209 pool, to the extent to which similar exclusions have been satisfied under any prior health  
1210 insurance coverage if the individual applies not later than 63 days following the date of  
1211 involuntary termination, other than for nonpayment of premiums, from health coverage.

1212 (b) If this Subsection [(9)] (8) applies, coverage in the pool shall be effective from the  
1213 date on which the prior coverage was terminated.

1214 [(10)] (9) Covered benefits available from the pool may not exceed a \$1,800,000  
1215 lifetime maximum, which includes a per enrollee calendar year maximum established by the  
1216 board.

1217 Section 17. Section 31A-29-114 is amended to read:

1218 **31A-29-114. Deductibles -- Copayments.**

1219 (1) (a) A pool policy shall impose a deductible on a per calendar year basis.

1220 (b) At least two deductible plans shall be offered.

1221 (c) The deductible is applied to all of the eligible medical expenses [~~as defined in~~  
1222 ~~Section 31A-29-113;~~] incurred by the enrollee until the deductible has been satisfied. There  
1223 are no benefits payable before the deductible has been satisfied.

1224 (d) The pool may offer separate deductibles for prescription benefits.

1225 (2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least  
1226 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess  
1227 of the mandatory deductible.

1228 (b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool  
1229 policy.

1230 (3) The board shall establish maximum aggregate out-of-pocket payments for eligible  
1231 medical expenses incurred by the enrollee for each of the deductible plans offered under  
1232 Subsection (1)(b).

1233 (4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments  
1234 under Subsection (3), the board may establish a coinsurance requirement to be imposed on



1235 eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

1236 (b) The circumstances in which the coinsurance authorized by this Subsection (4) may  
1237 be imposed shall be designated in the pool policy.

1238 (c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to  
1239 exceed 5% of eligible medical expenses.

1240 (5) The limits on maximum aggregate out-of-pocket payments for eligible medical  
1241 expenses incurred by the enrollee under this section may not include out-of-pocket payments  
1242 for prescription benefits.

1243 Section 18. Section **31A-29-115** is amended to read:

1244 **31A-29-115. Cancellation -- Notice.**

1245 (1) ~~[(a)]~~ On the date of renewal, the pool may cancel an enrollee's policy if:

1246 ~~[(i)]~~ (a) the enrollee's health condition does not meet the criteria established in  
1247 Subsection **31A-29-111(5)**; and

1248 ~~[(ii)]~~ (b) the pool has provided written notice to the enrollee's last-known address no  
1249 less than 60 days before cancellation~~[-and]~~.

1250 ~~[(iii) at least one individual carrier has not reached the individual enrollment cap  
1251 established in Section **31A-30-110**.]~~

1252 ~~[(b) The pool shall issue a certificate of insurability to an enrollee whose policy is  
1253 cancelled under Subsection (1)(a) for coverage under Subsection **31A-30-108(3)** if the  
1254 requirements of Subsection **31A-29-111(5)** are met.]~~

1255 (2) The pool may cancel an enrollee's policy at any time if:

1256 (a) the pool has provided written notice to the enrollee's last-known address no less  
1257 than 15 days before cancellation; and

1258 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive  
1259 months;

1260 (ii) there is nonpayment of premiums; or

1261 (iii) the pool determines that the enrollee does not meet the eligibility requirements set  
1262 forth in Section **31A-29-111**, in which case:

1263 (A) the policy may be retroactively terminated for the period of time in which the  
1264 enrollee was not eligible;

1265 (B) retroactive termination may not exceed three years; and

1266 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against  
1267 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection  
1268 [31A-29-119\(3\)](#).

1269 Section 19. Section **31A-30-103** is amended to read:

1270 **31A-30-103. Definitions.**

1271 As used in this chapter:

1272 (1) "Actuarial certification" means a written statement by a member of the American  
1273 Academy of Actuaries or other individual approved by the commissioner that a covered carrier  
1274 is in compliance with Sections [31A-30-106](#) and [31A-30-106.1](#), based upon the examination of  
1275 the covered carrier, including review of the appropriate records and of the actuarial  
1276 assumptions and methods used by the covered carrier in establishing premium rates for  
1277 applicable health benefit plans.

1278 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly  
1279 through one or more intermediaries, controls or is controlled by, or is under common control  
1280 with, a specified entity or person.

1281 (3) "Base premium rate" means, for each class of business as to a rating period, the  
1282 lowest premium rate charged or that could have been charged under a rating system for that  
1283 class of business by the covered carrier to covered insureds with similar case characteristics for  
1284 health benefit plans with the same or similar coverage.

1285 (4) (a) "Bona fide employer association" means an association of employers:

1286 (i) that meets the requirements of Subsection [31A-22-701\(2\)\(b\)](#);

1287 (ii) in which the employers of the association, either directly or indirectly, exercise  
1288 control over the plan;

1289 (iii) that is organized:

1290 (A) based on a commonality of interest between the employers and their employees  
1291 that participate in the plan by some common economic or representation interest or genuine  
1292 organizational relationship unrelated to the provision of benefits; and

1293 (B) to act in the best interests of its employers to provide benefits for the employer's  
1294 employees and their spouses and dependents, and other benefits relating to employment; and

1295 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

1296 (b) The commissioner shall consider the following with regard to determining whether

1297 an association of employers is a bona fide employer association under Subsection (4)(a):

1298 (i) how association members are solicited;

1299 (ii) who participates in the association;

1300 (iii) the process by which the association was formed;

1301 (iv) the purposes for which the association was formed, and what, if any, were the  
1302 pre-existing relationships of its members;

1303 (v) the powers, rights and privileges of employer members; and

1304 (vi) who actually controls and directs the activities and operations of the benefit  
1305 programs.

1306 (5) "Carrier" means any person or entity that provides health insurance in this state  
1307 including:

1308 (a) an insurance company;

1309 (b) a prepaid hospital or medical care plan;

1310 (c) a health maintenance organization;

1311 (d) a multiple employer welfare arrangement; and

1312 (e) any other person or entity providing a health insurance plan under this title.

1313 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means  
1314 demographic or other objective characteristics of a covered insured that are considered by the  
1315 carrier in determining premium rates for the covered insured.

1316 (b) "Case characteristics" do not include:

1317 (i) duration of coverage since the policy was issued;

1318 (ii) claim experience; and

1319 (iii) health status.

1320 (7) "Class of business" means all or a separate grouping of covered insureds that is  
1321 permitted by the commissioner in accordance with Section [31A-30-105](#).

1322 (8) "Conversion policy" means a policy providing coverage under the conversion  
1323 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

1324 (9) "Covered carrier" means any individual carrier or small employer carrier subject to  
1325 this chapter.

1326 (10) "Covered individual" means any individual who is covered under a health benefit  
1327 plan subject to this chapter.

1328 (11) "Covered insureds" means small employers and individuals who are issued a  
1329 health benefit plan that is subject to this chapter.

1330 (12) "Dependent" means an individual to the extent that the individual is defined to be  
1331 a dependent by:

1332 (a) the health benefit plan covering the covered individual; and

1333 (b) Chapter 22, Part 6, Accident and Health Insurance.

1334 (13) "Established geographic service area" means a geographical area approved by the  
1335 commissioner within which the carrier is authorized to provide coverage.

1336 (14) "Index rate" means, for each class of business as to a rating period for covered  
1337 insureds with similar case characteristics, the arithmetic average of the applicable base  
1338 premium rate and the corresponding highest premium rate.

1339 (15) "Individual carrier" means a carrier that provides coverage on an individual basis  
1340 through a health benefit plan regardless of whether:

1341 (a) coverage is offered through:

1342 (i) an association;

1343 (ii) a trust;

1344 (iii) a discretionary group; or

1345 (iv) other similar groups; or

1346 (b) the policy or contract is situated out-of-state.

1347 (16) "Individual conversion policy" means a conversion policy issued to:

1348 (a) an individual; or

1349 (b) an individual with a family.

1350 (17) "Individual coverage count" means the number of natural persons covered under a  
1351 carrier's health benefit products that are individual policies.

1352 (18) "Individual enrollment cap" means the percentage set by the commissioner in  
1353 accordance with Section [31A-30-110](#).

1354 (19) "New business premium rate" means, for each class of business as to a rating  
1355 period, the lowest premium rate charged or offered, or that could have been charged or offered,  
1356 by the carrier to covered insureds with similar case characteristics for newly issued health  
1357 benefit plans with the same or similar coverage.

1358 (20) "Premium" means money paid by covered insureds and covered individuals as a

1359 condition of receiving coverage from a covered carrier, including any fees or other  
1360 contributions associated with the health benefit plan.

1361 (21) (a) "Rating period" means the calendar period for which premium rates  
1362 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1363 (b) A covered carrier may not have:

1364 (i) more than one rating period in any calendar month; and

1365 (ii) no more than 12 rating periods in any calendar year.

1366 (22) "Resident" means an individual who has resided in this state for at least 12  
1367 consecutive months immediately preceding the date of application.

1368 (23) "Short-term limited duration insurance" means a health benefit product that:

1369 (a) is not renewable; and

1370 (b) has an expiration date specified in the contract that is less than 364 days after the  
1371 date the plan became effective.

1372 (24) "Small employer carrier" means a carrier that provides health benefit plans  
1373 covering eligible employees of one or more small employers in this state, regardless of  
1374 whether:

1375 (a) coverage is offered through:

1376 (i) an association;

1377 (ii) a trust;

1378 (iii) a discretionary group; or

1379 (iv) other similar grouping; or

1380 (b) the policy or contract is situated out-of-state.

1381 [~~(25) "Uninsurable" means an individual who:~~]

1382 [~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the~~  
1383 ~~underwriting criteria established in Subsection 31A-29-111(5); or]~~

1384 [~~(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and]~~

1385 [~~(ii) has a condition of health that does not meet consistently applied underwriting~~  
1386 ~~criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g)~~  
1387 ~~and (h) for which coverage the applicant is applying.]~~

1388 [~~(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for~~  
1389 ~~purposes of this formula:]~~

1390 ~~[(a) "CI" means the carrier's individual coverage count as of December 31 of the~~  
1391 ~~preceding year; and]~~

1392 ~~[(b) "UC" means the number of uninsurable individuals who were issued an individual~~  
1393 ~~policy on or after July 1, 1997.]~~

1394 Section 20. Section ~~31A-30-107~~ is amended to read:

1395 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**  
1396 **nonrenewal.**

1397 (1) Except as otherwise provided in this section, a small employer health benefit plan is  
1398 renewable and continues in force:

1399 (a) with respect to all eligible employees and dependents; and

1400 (b) at the option of the plan sponsor.

1401 (2) A small employer health benefit plan may be discontinued or nonrenewed:

1402 (a) for a network plan, if~~[(i)]~~ there is no longer any enrollee under the group health  
1403 plan who lives, resides, or works in:

1404 ~~[(A)]~~ (i) the service area of the covered carrier; or

1405 ~~[(B)]~~ (ii) the area for which the covered carrier is authorized to do business; ~~[and] or~~

1406 ~~[(ii) in the case of the small employer market, the small employer carrier applies the~~  
1407 ~~same criteria the small employer carrier would apply in denying enrollment in the plan under~~  
1408 ~~Subsection ~~31A-30-108~~(7); or]~~

1409 (b) for coverage made available in the small or large employer market only through an  
1410 association, if:

1411 (i) the employer's membership in the association ceases; and

1412 (ii) the coverage is terminated uniformly without regard to any health status-related  
1413 factor relating to any covered individual.

1414 (3) A small employer health benefit plan may be discontinued if:

1415 (a) a condition described in Subsection (2) exists;

1416 (b) except as prohibited by Section ~~31A-30-206~~, the plan sponsor fails to pay  
1417 premiums or contributions in accordance with the terms of the contract;

1418 (c) the plan sponsor:

1419 (i) performs an act or practice that constitutes fraud; or

1420 (ii) makes an intentional misrepresentation of material fact under the terms of the

1421 coverage;

1422 (d) the covered carrier:

1423 (i) elects to discontinue offering a particular small employer health benefit product

1424 delivered or issued for delivery in this state; and

1425 (ii) (A) provides notice of the discontinuation in writing:

1426 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1427 (II) at least 90 days before the date the coverage will be discontinued;

1428 (B) provides notice of the discontinuation in writing:

1429 (I) to the commissioner; and

1430 (II) at least three working days prior to the date the notice is sent to the affected plan

1431 sponsors, employees, and dependents of the plan sponsors or employees;

1432 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all

1433 other small employer health benefit products currently being offered by the small employer

1434 carrier in the market; and

1435 (D) in exercising the option to discontinue that product and in offering the option of

1436 coverage in this section, acts uniformly without regard to:

1437 (I) the claims experience of a plan sponsor;

1438 (II) any health status-related factor relating to any covered participant or beneficiary; or

1439 (III) any health status-related factor relating to any new participant or beneficiary who

1440 may become eligible for the coverage; or

1441 (e) the covered carrier:

1442 (i) elects to discontinue all of the covered carrier's small employer health benefit plans

1443 in:

1444 (A) the small employer market;

1445 (B) the large employer market; or

1446 (C) both the small employer and large employer markets; and

1447 (ii) (A) provides notice of the discontinuation in writing:

1448 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1449 (II) at least 180 days before the date the coverage will be discontinued;

1450 (B) provides notice of the discontinuation in writing:

1451 (I) to the commissioner in each state in which an affected insured individual is known

1452 to reside; and

1453 (II) at least 30 working days prior to the date the notice is sent to the affected plan  
1454 sponsors, employees, and the dependents of the plan sponsors or employees;

1455 (C) discontinues and nonrenews all plans issued or delivered for issuance in the  
1456 market; and

1457 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

1458 (4) A small employer health benefit plan may be discontinued or nonrenewed:

1459 (a) if a condition described in Subsection (2) exists; or

1460 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's  
1461 employer contribution requirements.

1462 (5) A small employer health benefit plan may be nonrenewed:

1463 (a) if a condition described in Subsection (2) exists; or

1464 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's  
1465 minimum participation requirements.

1466 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be  
1467 discontinued if after issuance of coverage the eligible employee:

1468 (i) engages in an act or practice that constitutes fraud in connection with the coverage;

1469 or

1470 (ii) makes an intentional misrepresentation of material fact in connection with the  
1471 coverage.

1472 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

1473 (i) 12 months after the date of discontinuance; and

1474 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies  
1475 to reenroll.

1476 (c) At the time the eligible employee's coverage is discontinued under Subsection  
1477 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when  
1478 coverage is discontinued.

1479 (d) An eligible employee may not be discontinued under this Subsection (6) because of  
1480 a fraud or misrepresentation that relates to health status.

1481 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to  
1482 the employer:



1483 (a) with respect to coverage provided to an employer member of the association; and

1484 (b) if the small employer health benefit plan is made available by a covered carrier in

1485 the employer market only through:

1486 (i) an association;

1487 (ii) a trust; or

1488 (iii) a discretionary group.

1489 (8) A covered carrier may modify a small employer health benefit plan only:

1490 (a) at the time of coverage renewal; and

1491 (b) if the modification is effective uniformly among all plans with that product.

1492 Section 21. Section **31A-30-108** is amended to read:

1493 **31A-30-108. Eligibility for small employer and individual market.**

1494 (1) (a) ~~[Small employer carriers shall accept residents]~~ A small employer carrier shall

1495 accept a small employer that applies for small group coverage as set forth in the Health

1496 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a) and PPACA, Sec. 2702.

1497 ~~[(b) Individual carriers shall accept residents for individual coverage pursuant to:]~~

1498 ~~[(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and]~~

1499 ~~[(ii) Subsection (3):]~~

1500 (b) An individual carrier shall accept an individual that applies for individual coverage

1501 as set forth in PPACA, Sec. 2702.

1502 (2) (a) ~~[Small]~~ A small employer ~~[carriers]~~ carrier shall offer to accept all eligible

1503 employees and their dependents at the same level of benefits under any health benefit plan

1504 provided to a small employer.

1505 (b) ~~[Small]~~ A small employer ~~[carriers]~~ carrier may:

1506 (i) request a small employer to submit a copy of the small employer's quarterly income

1507 tax withholdings to determine whether the employees for whom coverage is provided or

1508 requested are bona fide employees of the small employer; and

1509 (ii) deny or terminate coverage if the small employer refuses to provide documentation

1510 requested under Subsection (2)(b)(i).

1511 ~~[(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~

1512 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:]~~

1513 ~~[(a) the individual is not covered or eligible for coverage:]~~

1514 ~~[(i) (A) as an employee of an employer;]~~  
1515 ~~[(B) as a member of an association; or]~~  
1516 ~~[(C) as a member of any other group; and]~~  
1517 ~~[(ii) under:]~~  
1518 ~~[(A) a health benefit plan; or]~~  
1519 ~~[(B) a self-insured arrangement that provides coverage similar to that provided by a~~  
1520 ~~health benefit plan as defined in Section [31A-1-301](#);~~  
1521 ~~[(b) the individual is not covered and is not eligible for coverage under any public~~  
1522 ~~health benefits arrangement including:]~~  
1523 ~~[(i) the Medicare program established under Title XVIII of the Social Security Act;]~~  
1524 ~~[(ii) any act of Congress or law of this or any other state that provides benefits~~  
1525 ~~comparable to the benefits provided under this chapter; or]~~  
1526 ~~[(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter~~  
1527 ~~29, Comprehensive Health Insurance Pool Act;]~~  
1528 ~~[(c) unless the maximum benefit has been reached the individual is not covered or~~  
1529 ~~eligible for coverage under any:]~~  
1530 ~~[(i) Medicare supplement policy;]~~  
1531 ~~[(ii) conversion option;]~~  
1532 ~~[(iii) continuation or extension under COBRA; or]~~  
1533 ~~[(iv) state extension;]~~  
1534 ~~[(d) the individual has not terminated or declined coverage described in Subsection~~  
1535 ~~(3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for~~  
1536 ~~individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),~~  
1537 ~~in which case, the requirement of this Subsection (3)(d) does not apply; and]~~  
1538 ~~[(e) the individual is certified as ineligible for the Health Insurance Pool if:]~~  
1539 ~~[(i) the individual applies for coverage with the Comprehensive Health Insurance Pool~~  
1540 ~~within 30 days after being rejected or refused coverage by the covered carrier and reapplies for~~  
1541 ~~coverage with that covered carrier within 30 days after the date of issuance of a certificate~~  
1542 ~~under Subsection [31A-29-111\(5\)\(c\)](#); or]~~  
1543 ~~[(ii) the individual applies for coverage with any individual carrier within 45 days~~  
1544 ~~after:]~~

1545           ~~[(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or]~~  
1546           ~~[(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the~~  
1547 ~~individual applied first for coverage with the Comprehensive Health Insurance Pool.]~~  
1548           ~~[(4) (a) If coverage is obtained under Subsection (3)(c)(i) and the required premium is~~  
1549 ~~paid, the effective date of coverage shall be the first day of the month following the individual's~~  
1550 ~~submission of a completed insurance application to that covered carrier.]~~  
1551           ~~[(b) If coverage is obtained under Subsection (3)(c)(ii) and the required premium is~~  
1552 ~~paid, the effective date of coverage shall be the day following the:]~~  
1553           ~~[(i) cancellation of coverage under Subsection 31A-29-115(1); or]~~  
1554           ~~[(ii) submission of a completed insurance application to the Comprehensive Health~~  
1555 ~~Insurance Pool].~~  
1556           ~~[(5) (a) An individual carrier is not required to accept individuals for coverage under~~  
1557 ~~Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]~~  
1558           ~~[(b) A carrier described in Subsection (5)(a) may not issue new individual policies in~~  
1559 ~~the state for five years from July 1, 1997.]~~  
1560           ~~[(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new~~  
1561 ~~policies after July 1, 1999, which may only be granted if:]~~  
1562           ~~[(i) the carrier accepts uninsurables as is required of a carrier entering the market under~~  
1563 ~~Subsection 31A-30-110; and]~~  
1564           ~~[(ii) the commissioner finds that the carrier's issuance of new individual policies:]~~  
1565           ~~[(A) is in the best interests of the state; and]~~  
1566           ~~[(B) does not provide an unfair advantage to the carrier.]~~  
1567           ~~[(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29,~~  
1568 ~~Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is~~  
1569 ~~capped or suspended, an individual carrier may decline to accept individuals applying for~~  
1570 ~~individual enrollment, other than individuals applying for coverage as set forth in Health~~  
1571 ~~Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]~~  
1572           ~~[(b) Within two calendar days of taking action under Subsection (6)(a), an individual~~  
1573 ~~carrier will provide written notice to the department.]~~  
1574           ~~[(7) (a) If a small employer carrier offers health benefit plans to small employers~~  
1575 ~~through a network plan, the small employer carrier may:]~~

1576 ~~[(i) limit the employers that may apply for the coverage to those employers with~~  
1577 ~~eligible employees who live, reside, or work in the service area for the network plan; and]~~  
1578 ~~[(ii) within the service area of the network plan, deny coverage to an employer if the~~  
1579 ~~small employer carrier has demonstrated to the commissioner that the small employer carrier:]~~  
1580 ~~[(A) will not have the capacity to deliver services adequately to enrollees of any~~  
1581 ~~additional groups because of the small employer carrier's obligations to existing group contract~~  
1582 ~~holders and enrollees; and]~~  
1583 ~~[(B) applies this section uniformly to all employers without regard to:]~~  
1584 ~~[(f) the claims experience of an employer, an employer's employee, or a dependent of~~  
1585 ~~an employee; or]~~  
1586 ~~[(H) any health status-related factor relating to an employee or dependent of an~~  
1587 ~~employee].~~

1588 ~~[(b) (i) A small employer carrier that denies a health benefit product to an employer in~~  
1589 ~~any service area in accordance with this section may not offer coverage in the small employer~~  
1590 ~~market within the service area to any employer for a period of 180 days after the date the~~  
1591 ~~coverage is denied.]~~

1592 ~~[(ii) This Subsection (7)(b) does not:]~~

1593 ~~[(A) limit the small employer carrier's ability to renew coverage that is in force; or]~~

1594 ~~[(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~  
1595 ~~force.]~~

1596 ~~[(c) Coverage offered within a service area after the 180-day period specified in~~  
1597 ~~Subsection (7)(b) is subject to the requirements of this section.]~~

1598 Section 22. Section **31A-30-117** is amended to read:

1599 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**

1600 (1) (a) After complying with the reporting requirements of Section [63M-1-2505.5](#), the  
1601 commissioner may adopt administrative rules that change the rating and underwriting  
1602 requirements of this chapter as necessary to transition the insurance market to meet federal  
1603 qualified health plan standards and rating practices under PPACA.

1604 (b) Administrative rules adopted by the commissioner under this section may include:

1605 (i) the regulation of health benefit plans as described in Subsections [31A-2-212\(5\)\(a\)](#)

1606 and (b); and

- 1607 (ii) disclosure of records and information required by PPACA and state law.
- 1608 (c) (i) The commissioner shall establish by administrative rule one statewide open
- 1609 enrollment period that applies to the individual insurance market that is not on the PPACA
- 1610 certified individual exchange.
- 1611 (ii) The statewide open enrollment period:
- 1612 (A) may be shorter, but no longer than the open enrollment period established for the
- 1613 individual insurance market offered in the PPACA certified exchange; and
- 1614 (B) may not be extended beyond the dates of the open enrollment period established
- 1615 for the individual insurance market offered in the PPACA certified exchange.
- 1616 (2) A carrier that offers health benefit plans in the individual market that is not part of
- 1617 the individual PPACA certified exchange:
- 1618 (a) shall open enrollment:
- 1619 (i) during the statewide open enrollment period established in Subsection (1)(c); and
- 1620 (ii) at other times, for qualifying events, as determined by administrative rule adopted
- 1621 by the commissioner; and
- 1622 (b) may open enrollment at any time.
- 1623 [~~(3) (a) The commissioner shall identify a new mandated benefit that is in excess of the~~
- 1624 ~~essential health benefits required by PPACA.]~~
- 1625 [~~(b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to~~
- 1626 ~~defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c)~~
- 1627 ~~directly to the qualified health plan issuer on behalf of an individual who receives an advance~~
- 1628 ~~premium tax credit under PPACA.]~~
- 1629 [~~(c) The state shall quantify the cost attributable to each additional mandated benefit~~
- 1630 ~~specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost~~
- 1631 ~~associated with the mandated benefit, which shall be:]~~
- 1632 [~~(i) calculated in accordance with generally accepted actuarial principles and~~
- 1633 ~~methodologies;]~~
- 1634 [~~(ii) conducted by a member of the American Academy of Actuaries; and]~~
- 1635 [~~(iii) reported to the commissioner and to the individual exchange operating in the~~
- 1636 ~~state.]~~
- 1637 [~~(d) The commissioner may require a proponent of a new mandated benefit under~~

1638 ~~Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance~~  
1639 ~~with Subsection (3)(c). The commissioner may use the cost information provided under this~~  
1640 ~~Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under~~  
1641 ~~Subsection (3)(b).]~~

1642 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,  
1643 or federal regulation, the commissioner shall allow a health insurer to choose to continue  
1644 coverage and individuals and small employers to choose to re-enroll in coverage in  
1645 nongrandfathered health coverage that is not in compliance with market reforms required by  
1646 PPACA.

1647 Section 23. Section **31A-30-118** is enacted to read:

1648 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**  
1649 **mandates -- Cost of additional benefits.**

1650 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the  
1651 essential health benefits required by PPACA.

1652 (b) The state shall quantify the cost attributable to each additional mandated benefit  
1653 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost  
1654 associated with the mandated benefit, which shall be:

1655 (i) calculated in accordance with generally accepted actuarial principles and  
1656 methodologies;

1657 (ii) conducted by a member of the American Academy of Actuaries; and

1658 (iii) reported to the commissioner and to the individual exchange operating in the state.

1659 (c) The commissioner may require a proponent of a new mandated benefit under  
1660 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance  
1661 with Subsection (1)(b). The commissioner may use the cost information provided under this  
1662 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

1663 (2) If the state is required to defray the cost of additional required benefits under the  
1664 provisions of 45 C.F.R. 155.170:

1665 (a) the state shall make the required payments:

1666 (i) in accordance with Subsection (3); and

1667 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

1668 (b) an issuer of a qualified health plan that receives a payment under the provisions of

1669 Subsection (1) and 45 C.F.R. 155.170 shall:

1670 (i) reduce the premium charged to the individual on whose behalf the issuer will be  
1671 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection  
1672 (1); or

1673 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an  
1674 individual on whose behalf the issuer received a payment under Subsection (1), in an amount  
1675 equal to the amount of the payment under Subsection (1); and

1676 (c) a premium rebate made under this section is not a prohibited inducement under  
1677 Section 31A-23a-402.5.

1678 (3) A payment required under 45 C.F.R. 155.170(c) shall:

1679 (a) unless otherwise required by PPACA, be based on a statewide average of the cost  
1680 of the additional benefit for all issuers who are entitled to payment under the provisions of 45  
1681 C.F.R. 155.70; and

1682 (b) be submitted to an issuer through a process established and administered by:

1683 (i) the federal marketplace exchange for the state under PPACA for individual health  
1684 plans; or

1685 (ii) Avenue H small employer market exchange for qualified health plans offered on  
1686 the exchange.

1687 (4) The commissioner:

1688 (a) may adopt rules as necessary to administer the provisions of this section and 45  
1689 C.F.R. 155.170; and

1690 (b) may not establish or implement the process for submitting the payments to an issuer  
1691 under Subsection (3)(b)(i) unless the cost of establishing and implementing the process for  
1692 submitting payments is paid for by the federal exchange marketplace.

1693 Section 24. Section **31A-30-301** is enacted to read:

1694 **Part 3. Individual and Small Employer Risk Adjustment Act**

1695 **31A-30-301. Title.**

1696 This part is known as the "Individual and Small Employer Risk Adjustment Act."

1697 Section 25. Section **31A-30-302** is enacted to read:

1698 **31A-30-302. Creation of state risk adjustment program.**

1699 (1) The commissioner shall convene a group of stakeholders and actuaries to assist the

1700 commissioner with the evaluation or the risk adjustment options described in Subsection (2). If  
1701 the commissioner determines that a state-based risk adjustment program is in the best interest  
1702 of the state, the commissioner shall establish an individual and small employer market risk  
1703 adjustment program in accordance with 42 U.S.C. 18063 and this section.

1704 (2) The risk adjustment program adopted by the commissioner may include one of the  
1705 following models:

1706 (a) continue the United States Department of Health and Human Services  
1707 administration of the federal model for risk adjustment for the individual and small employer  
1708 market in the state;

1709 (b) have the state administer the federal model for risk adjustment for the individual  
1710 and small employer market in the state;

1711 (c) establish and operate a state based risk adjustment program for the individual and  
1712 small employer market in the state; or

1713 (d) another risk adjustment model developed by the commissioner under Subsection  
1714 (1).

1715 (3) Before adopting one of the models described in Subsection (2), the commissioner:

1716 (a) may enter into contracts to carry out the services needed to evaluate and establish  
1717 one of the risk adjustment options described in Subsection (2); and

1718 (b) shall, prior to October 30, 2014, comply with the reporting requirements of Section  
1719 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options  
1720 described in Subsection (2).

1721 (4) The commissioner may:

1722 (a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah  
1723 Administrative Rulemaking Act, that require an insurer that is subject to the state based risk  
1724 adjustment program to submit data to the all payers claims database created under Section  
1725 26-33a-106.1; and

1726 (b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act,  
1727 to cover the ongoing administrative cost of running the state based risk adjustment program.

1728 Section 26. Section **31A-30-303** is enacted to read:

1729 **31A-30-303. Enterprise fund.**

1730 (1) There is created an enterprise fund known as the Individual and Small Employer



1731 Risk Adjustment Enterprise Fund.

1732 (2) The following funds shall be credited to the fund:

1733 (a) appropriations from the General Fund;

1734 (b) fees established by the commissioner under Section [31A-30-302](#);

1735 (c) risk adjustment payments received from insurers participating in the risk adjustment  
1736 program; and

1737 (d) all interest and dividends earned on the fund's assets.

1738 (3) All money received by the fund shall be deposited in compliance with Section

1739 [51-4-1](#) and shall be held by the state treasurer and invested in accordance with Title 51,

1740 Chapter 7, State Money Management Act.

1741 (4) The fund shall comply with the accounting policies, procedures, and reporting  
1742 requirements established by the Division of Finance.

1743 (5) The fund shall comply with Title 63A, Utah Administrative Services Code.

1744 (6) The fund shall be used to implement and operate the risk adjustment program  
1745 created by this part.

1746 Section 27. Section **63A-5-205** is amended to read:

1747 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**  
1748 **coverage.**

1749 (1) As used in this section:

1750 (a) "Capital developments" has the same meaning as provided in Section [63A-5-104](#).

1751 (b) "Capital improvements" has the same meaning as provided in Section [63A-5-104](#).

1752 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section  
1753 [34A-2-104](#) who:

1754 (i) works at least 30 hours per calendar week; and

1755 (ii) meets employer eligibility waiting requirements for health care insurance which  
1756 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of  
1757 hire.

1758 (d) "Health benefit plan" has the same meaning as provided in Section [31A-1-301](#).

1759 (e) "Qualified health insurance coverage" is as defined in Section [26-40-115](#).

1760 (f) "Subcontractor" has the same meaning provided for in Section [63A-5-208](#).

1761 (2) In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the director

1762 may:

1763 (a) subject to Subsection (3), enter into contracts for any work or professional services  
1764 which the division or the State Building Board may do or have done; and

1765 (b) as a condition of any contract for architectural or engineering services, prohibit the  
1766 architect or engineer from retaining a sales or agent engineer for the necessary design work.

1767 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design  
1768 or construction contracts entered into by the division or the State Building Board on or after  
1769 July 1, 2009, and:

1770 (i) applies to a prime contractor if the prime contract is in the amount of \$1,500,000 or  
1771 greater; and

1772 (ii) applies to a subcontractor if the subcontract is in the amount of \$750,000 or greater.

1773 (b) This Subsection (3) does not apply:

1774 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

1775 (ii) if the contract is a sole source contract;

1776 (iii) if the contract is an emergency procurement; or

1777 (iv) to a change order as defined in Section [63G-6a-103](#), or a modification to a  
1778 contract, when the contract does not meet the threshold required by Subsection (3)(a).

1779 (c) A person who intentionally uses change orders or contract modifications to  
1780 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

1781 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that  
1782 the contractor has and will maintain an offer of qualified health insurance coverage for the  
1783 contractor's employees and the employees' dependents.

1784 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor  
1785 shall demonstrate to the director that the subcontractor has and will maintain an offer of  
1786 qualified health insurance coverage for the subcontractor's employees and the employees'  
1787 dependents.

1788 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)  
1789 during the duration of the contract is subject to penalties in accordance with administrative  
1790 rules adopted by the division under Subsection (3)(f).

1791 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
1792 requirements of Subsection (3)(d)(ii).

1793 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)  
1794 during the duration of the contract is subject to penalties in accordance with administrative  
1795 rules adopted by the division under Subsection (3)(f).

1796 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
1797 requirements of Subsection (3)(d)(i).

1798 (f) The division shall adopt administrative rules:

1799 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1800 (ii) in coordination with:

1801 (A) the Department of Environmental Quality in accordance with Section 19-1-206;

1802 (B) the Department of Natural Resources in accordance with Section 79-2-404;

1803 (C) a public transit district in accordance with Section 17B-2a-818.5;

1804 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

1805 (E) the Department of Transportation in accordance with Section 72-6-107.5; and

1806 (F) the Legislature's Administrative Rules Review Committee; and

1807 (iii) which establish:

1808 (A) the requirements and procedures a contractor must follow to demonstrate to the  
1809 director compliance with this Subsection (3) which shall include:

1810 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)  
1811 or (ii) more than twice in any 12-month period; and

1812 (II) that the actuarially equivalent determination required for the qualified health  
1813 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the  
1814 department or division with a written statement of actuarial equivalency from either:

1815 (Aa) the Utah Insurance Department;

1816 (Bb) an actuary selected by the contractor or the contractor's insurer; or

1817 (Cc) an underwriter who is responsible for developing the employer group's premium  
1818 rates;

1819 (B) the penalties that may be imposed if a contractor or subcontractor intentionally  
1820 violates the provisions of this Subsection (3), which may include:

1821 (I) a three-month suspension of the contractor or subcontractor from entering into  
1822 future contracts with the state upon the first violation;

1823 (II) a six-month suspension of the contractor or subcontractor from entering into future

1824 contracts with the state upon the second violation;

1825 (III) an action for debarment of the contractor or subcontractor in accordance with  
1826 Section 63G-6a-904 upon the third or subsequent violation; and

1827 (IV) monetary penalties which may not exceed 50% of the amount necessary to  
1828 purchase qualified health insurance coverage for an employee and the dependents of an  
1829 employee of the contractor or subcontractor who was not offered qualified health insurance  
1830 coverage during the duration of the contract; and

1831 (C) a website on which the department shall post the benchmark for the qualified  
1832 health insurance coverage identified in Subsection (1)(e).

1833 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or  
1834 subcontractor who intentionally violates the provisions of this section shall be liable to the  
1835 employee for health care costs that would have been covered by qualified health insurance  
1836 coverage.

1837 (ii) An employer has an affirmative defense to a cause of action under Subsection  
1838 (3)(g)(i) if:

1839 (A) the employer relied in good faith on a written statement of actuarial equivalency  
1840 provided by:

1841 (I) an actuary; or

1842 (II) an underwriter who is responsible for developing the employer group's premium  
1843 rates; or

1844 (B) the department determines that compliance with this section is not required under  
1845 the provisions of Subsection (3)(b).

1846 (iii) An employee has a private right of action only against the employee's employer to  
1847 enforce the provisions of this Subsection (3)(g).

1848 (h) Any penalties imposed and collected under this section shall be deposited into the  
1849 Medicaid Restricted Account created by Section 26-18-402.

1850 (i) The failure of a contractor or subcontractor to provide qualified health insurance  
1851 coverage as required by this section:

1852 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,  
1853 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah  
1854 Procurement Code; and

1855 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or  
1856 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
1857 or construction.

1858 (4) The judgment of the director as to the responsibility and qualifications of a bidder  
1859 is conclusive, except in case of fraud or bad faith.

1860 (5) The division shall make all payments to the contractor for completed work in  
1861 accordance with the contract and pay the interest specified in the contract on any payments that  
1862 are late.

1863 (6) If any payment on a contract with a private contractor to do work for the division or  
1864 the State Building Board is retained or withheld, it shall be retained or withheld and released as  
1865 provided in Section 13-8-5.

1866 Section 28. Section 63C-9-403 is amended to read:

1867 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

1868 (1) For purposes of this section:

1869 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
1870 34A-2-104 who:

1871 (i) works at least 30 hours per calendar week; and

1872 (ii) meets employer eligibility waiting requirements for health care insurance which  
1873 may not exceed the first of the calendar month following [90] 60 days from the date of hire.

1874 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

1875 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

1876 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

1877 (2) (a) Except as provided in Subsection (3), this section applies to a design or  
1878 construction contract entered into by the board or on behalf of the board on or after July 1,  
1879 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).

1880 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
1881 amount of \$1,500,000 or greater.

1882 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
1883 \$750,000 or greater.

1884 (3) This section does not apply if:

1885 (a) the application of this section jeopardizes the receipt of federal funds;

1886 (b) the contract is a sole source contract; or

1887 (c) the contract is an emergency procurement.

1888 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),  
1889 or a modification to a contract, when the contract does not meet the initial threshold required  
1890 by Subsection (2).

1891 (b) A person who intentionally uses change orders or contract modifications to  
1892 circumvent the requirements of Subsection (2) is guilty of an infraction.

1893 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive  
1894 director that the contractor has and will maintain an offer of qualified health insurance  
1895 coverage for the contractor's employees and the employees' dependents during the duration of  
1896 the contract.

1897 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor  
1898 shall demonstrate to the executive director that the subcontractor has and will maintain an offer  
1899 of qualified health insurance coverage for the subcontractor's employees and the employees'  
1900 dependents during the duration of the contract.

1901 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during  
1902 the duration of the contract is subject to penalties in accordance with administrative rules  
1903 adopted by the division under Subsection (6).

1904 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
1905 requirements of Subsection (5)(b).

1906 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
1907 the duration of the contract is subject to penalties in accordance with administrative rules  
1908 adopted by the department under Subsection (6).

1909 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
1910 requirements of Subsection (5)(a).

1911 (6) The department shall adopt administrative rules:

1912 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1913 (b) in coordination with:

1914 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

1915 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

1916 (iii) the State Building Board in accordance with Section [63A-5-205](#);

- 1917 (iv) a public transit district in accordance with Section [17B-2a-818.5](#);
- 1918 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and
- 1919 (vi) the Legislature's Administrative Rules Review Committee; and
- 1920 (c) which establish:
- 1921 (i) the requirements and procedures a contractor must follow to demonstrate to the
- 1922 executive director compliance with this section which shall include:
- 1923 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
- 1924 (b) more than twice in any 12-month period; and
- 1925 (B) that the actuarially equivalent determination required for the qualified health
- 1926 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
- 1927 department or division with a written statement of actuarial equivalency from either:
- 1928 (I) the Utah Insurance Department;
- 1929 (II) an actuary selected by the contractor or the contractor's insurer; or
- 1930 (III) an underwriter who is responsible for developing the employer group's premium
- 1931 rates;
- 1932 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
- 1933 violates the provisions of this section, which may include:
- 1934 (A) a three-month suspension of the contractor or subcontractor from entering into
- 1935 future contracts with the state upon the first violation;
- 1936 (B) a six-month suspension of the contractor or subcontractor from entering into future
- 1937 contracts with the state upon the second violation;
- 1938 (C) an action for debarment of the contractor or subcontractor in accordance with
- 1939 Section [63G-6a-904](#) upon the third or subsequent violation; and
- 1940 (D) monetary penalties which may not exceed 50% of the amount necessary to
- 1941 purchase qualified health insurance coverage for employees and dependents of employees of
- 1942 the contractor or subcontractor who were not offered qualified health insurance coverage
- 1943 during the duration of the contract; and
- 1944 (iii) a website on which the department shall post the benchmark for the qualified
- 1945 health insurance coverage identified in Subsection (1)(c).
- 1946 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
- 1947 subcontractor who intentionally violates the provisions of this section shall be liable to the

1948 employee for health care costs that would have been covered by qualified health insurance  
1949 coverage.

1950 (ii) An employer has an affirmative defense to a cause of action under Subsection  
1951 (7)(a)(i) if:

1952 (A) the employer relied in good faith on a written statement of actuarial equivalency  
1953 provided by:

1954 (I) an actuary; or

1955 (II) an underwriter who is responsible for developing the employer group's premium  
1956 rates; or

1957 (B) the department determines that compliance with this section is not required under  
1958 the provisions of Subsection (3) or (4).

1959 (b) An employee has a private right of action only against the employee's employer to  
1960 enforce the provisions of this Subsection (7).

1961 (8) Any penalties imposed and collected under this section shall be deposited into the  
1962 Medicaid Restricted Account created in Section [26-18-402](#).

1963 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
1964 coverage as required by this section:

1965 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
1966 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah  
1967 Procurement Code; and

1968 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
1969 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
1970 or construction.

1971 Section 29. Section **63I-1-231 (Effective 07/01/14)** is amended to read:

1972 **63I-1-231 (Effective 07/01/14). Repeal dates, Title 31A.**

1973 (1) Section [31A-2-208.5](#), Comparison tables, is repealed July 1, 2015.

1974 (2) Section [31A-2-217](#), Coordination with other states, is repealed July 1, 2023.

1975 (3) Section [31A-22-619.6](#), Coordination of benefits with workers' compensation  
1976 claim--Health insurer's duty to pay, is repealed on July 1, 2018.

1977 (4) Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is repealed July  
1978 1, 2015.



- 1979 Section 30. Section **63M-1-2504** is amended to read:
- 1980 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
- 1981 (1) There is created within the Governor's Office of Economic Development the Office
- 1982 of Consumer Health Services.
- 1983 (2) The office shall:
- 1984 (a) in cooperation with the Insurance Department, the Department of Health, and the
- 1985 Department of Workforce Services, and in accordance with the electronic standards developed
- 1986 under Sections **31A-22-635** and **63M-1-2506**, create a Health Insurance Exchange that:
- 1987 (i) provides information to consumers about private and public health programs for
- 1988 which the consumer may qualify;
- 1989 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
- 1990 on the Health Insurance Exchange; and
- 1991 (iii) includes information and a link to enrollment in premium assistance programs and
- 1992 other government assistance programs;
- 1993 (b) contract with one or more private vendors for:
- 1994 (i) administration of the enrollment process on the Health Insurance Exchange,
- 1995 including establishing a mechanism for consumers to compare health benefit plan features on
- 1996 the exchange and filter the plans based on consumer preferences;
- 1997 (ii) the collection of health insurance premium payments made for a single policy by
- 1998 multiple payers, including the policyholder, one or more employers of one or more individuals
- 1999 covered by the policy, government programs, and others; and
- 2000 (iii) establishing a call center in accordance with Subsection ~~[(3)]~~ (4);
- 2001 (c) assist employers with a free or low cost method for establishing mechanisms for the
- 2002 purchase of health insurance by employees using pre-tax dollars;
- 2003 (d) establish a list on the Health Insurance Exchange of insurance producers who, in
- 2004 accordance with Section **31A-30-209**, are appointed producers for the Health Insurance
- 2005 Exchange; ~~[and]~~
- 2006 (e) submit, before November 1, an annual written report to the Business and Labor
- 2007 Interim Committee and the Health System Reform Task Force regarding the operations of the
- 2008 Health Insurance Exchange required by this chapter~~[-]; and~~
- 2009 (f) in accordance with Subsection (3), provide a form to a small employer that certifies:

2010 (i) that the small employer offered a qualified health plan to the small employer's  
2011 employees; and

2012 (ii) the period of time within the taxable year in which the small employer maintained  
2013 the qualified health plan coverage.

2014 (3) The form required by Subsection (2)(f) shall be provided to a small employer if:

2015 (a) the small employer selected a qualified health plan on the small employer health  
2016 exchange created by this section; or

2017 (b) (i) the small employer selected a health plan in the small employer market that is  
2018 not offered through the exchange created by this section; and

2019 (ii) the issuer of the health plan selected by the small employer submits to the office, in  
2020 a form and manner required by the office:

2021 (A) an affidavit from a member of the American Academy of Actuaries stating that  
2022 based on generally accepted actuarial principles and methodologies the issuer's health plan  
2023 meets the benefit and actuarial requirements for a qualified health plan under PPACA as  
2024 defined in Section [31A-1-301](#); and

2025 (B) an affidavit from the issuer that includes the dates of coverage for the small  
2026 employer during the taxable year.

2027 [~~3~~] (4) A call center established by the office:

2028 (a) shall provide unbiased answers to questions concerning exchange operations, and  
2029 plan information, to the extent the plan information is posted on the exchange by the insurer;  
2030 and

2031 (b) may not:

2032 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

2033 (ii) receive producer compensation through the Health Insurance Exchange; and

2034 (iii) be designated as the default producer for an employer group that enters the Health  
2035 Insurance Exchange without a producer.

2036 [~~4~~] (5) The office:

2037 (a) may not:

2038 (i) regulate health insurers, health insurance plans, health insurance producers, or  
2039 health insurance premiums charged in the exchange;

2040 (ii) adopt administrative rules, except as provided in Section [63M-1-2506](#); or

2041 (iii) act as an appeals entity for resolving disputes between a health insurer and an  
2042 insured;

2043 (b) may establish and collect a fee for the cost of the exchange transaction in  
2044 accordance with Section 63J-1-504 for:

2045 (i) processing an application for a health benefit plan;

2046 (ii) accepting, processing, and submitting multiple premium payment sources;

2047 (iii) providing a mechanism for consumers to filter and compare health benefit plans in  
2048 the exchange based on consumer preferences; and

2049 (iv) funding the call center; and

2050 (c) shall separately itemize the fee established under Subsection [~~(4)~~] (5)(b) as part of  
2051 the cost displayed for the employer selecting coverage on the exchange.

2052 Section 31. Section 72-6-107.5 is amended to read:

2053 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**  
2054 **insurance coverage.**

2055 (1) For purposes of this section:

2056 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
2057 34A-2-104 who:

2058 (i) works at least 30 hours per calendar week; and

2059 (ii) meets employer eligibility waiting requirements for health care insurance which  
2060 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of  
2061 hire.

2062 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2063 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

2064 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2065 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered  
2066 into by the department on or after July 1, 2009, for construction or design of highways and to a  
2067 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

2068 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
2069 amount of \$1,500,000 or greater.

2070 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
2071 \$750,000 or greater.

- 2072 (3) This section does not apply if:
- 2073 (a) the application of this section jeopardizes the receipt of federal funds;
- 2074 (b) the contract is a sole source contract; or
- 2075 (c) the contract is an emergency procurement.
- 2076 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
- 2077 or a modification to a contract, when the contract does not meet the initial threshold required
- 2078 by Subsection (2).
- 2079 (b) A person who intentionally uses change orders or contract modifications to
- 2080 circumvent the requirements of Subsection (2) is guilty of an infraction.
- 2081 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
- 2082 the contractor has and will maintain an offer of qualified health insurance coverage for the
- 2083 contractor's employees and the employees' dependents during the duration of the contract.
- 2084 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
- 2085 demonstrate to the department that the subcontractor has and will maintain an offer of qualified
- 2086 health insurance coverage for the subcontractor's employees and the employees' dependents
- 2087 during the duration of the contract.
- 2088 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
- 2089 the duration of the contract is subject to penalties in accordance with administrative rules
- 2090 adopted by the department under Subsection (6).
- 2091 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
- 2092 requirements of Subsection (5)(b).
- 2093 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
- 2094 the duration of the contract is subject to penalties in accordance with administrative rules
- 2095 adopted by the department under Subsection (6).
- 2096 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
- 2097 requirements of Subsection (5)(a).
- 2098 (6) The department shall adopt administrative rules:
- 2099 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
- 2100 (b) in coordination with:
- 2101 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);
- 2102 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

- 2103 (iii) the State Building Board in accordance with Section [63A-5-205](#);
- 2104 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);
- 2105 (v) a public transit district in accordance with Section [17B-2a-818.5](#); and
- 2106 (vi) the Legislature's Administrative Rules Review Committee; and
- 2107 (c) which establish:
  - 2108 (i) the requirements and procedures a contractor must follow to demonstrate to the
  - 2109 department compliance with this section which shall include:
    - 2110 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
    - 2111 (b) more than twice in any 12-month period; and
    - 2112 (B) that the actuarially equivalent determination required for qualified health insurance
    - 2113 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
    - 2114 division with a written statement of actuarial equivalency from either:
      - 2115 (I) the Utah Insurance Department;
      - 2116 (II) an actuary selected by the contractor or the contractor's insurer; or
      - 2117 (III) an underwriter who is responsible for developing the employer group's premium
      - 2118 rates;
    - 2119 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
    - 2120 violates the provisions of this section, which may include:
      - 2121 (A) a three-month suspension of the contractor or subcontractor from entering into
      - 2122 future contracts with the state upon the first violation;
      - 2123 (B) a six-month suspension of the contractor or subcontractor from entering into future
      - 2124 contracts with the state upon the second violation;
      - 2125 (C) an action for debarment of the contractor or subcontractor in accordance with
      - 2126 Section [63G-6a-904](#) upon the third or subsequent violation; and
      - 2127 (D) monetary penalties which may not exceed 50% of the amount necessary to
      - 2128 purchase qualified health insurance coverage for an employee and a dependent of the employee
      - 2129 of the contractor or subcontractor who was not offered qualified health insurance coverage
      - 2130 during the duration of the contract; and
    - 2131 (iii) a website on which the department shall post the benchmark for the qualified
    - 2132 health insurance coverage identified in Subsection (1)(c).
  - 2133 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or

2134 subcontractor who intentionally violates the provisions of this section shall be liable to the  
2135 employee for health care costs that would have been covered by qualified health insurance  
2136 coverage.

2137 (ii) An employer has an affirmative defense to a cause of action under Subsection  
2138 (7)(a)(i) if:

2139 (A) the employer relied in good faith on a written statement of actuarial equivalency  
2140 provided by:

2141 (I) an actuary; or

2142 (II) an underwriter who is responsible for developing the employer group's premium  
2143 rates; or

2144 (B) the department determines that compliance with this section is not required under  
2145 the provisions of Subsection (3) or (4).

2146 (b) An employee has a private right of action only against the employee's employer to  
2147 enforce the provisions of this Subsection (7).

2148 (8) Any penalties imposed and collected under this section shall be deposited into the  
2149 Medicaid Restricted Account created in Section [26-18-402](#).

2150 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
2151 coverage as required by this section:

2152 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
2153 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah  
2154 Procurement Code; and

2155 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
2156 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
2157 or construction.

2158 Section 32. Section **79-2-404** is amended to read:

2159 **79-2-404. Contracting powers of department -- Health insurance coverage.**

2160 (1) For purposes of this section:

2161 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
2162 [34A-2-104](#) who:

2163 (i) works at least 30 hours per calendar week; and

2164 (ii) meets employer eligibility waiting requirements for health care insurance which

2165 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of  
2166 hire.

2167 (b) "Health benefit plan" has the same meaning as provided in Section [31A-1-301](#).

2168 (c) "Qualified health insurance coverage" is as defined in Section [26-40-115](#).

2169 (d) "Subcontractor" has the same meaning provided for in Section [63A-5-208](#).

2170 (2) (a) Except as provided in Subsection (3), this section applies a design or  
2171 construction contract entered into by, or delegated to, the department or a division, board, or  
2172 council of the department on or after July 1, 2009, and to a prime contractor or to a  
2173 subcontractor in accordance with Subsection (2)(b).

2174 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
2175 amount of \$1,500,000 or greater.

2176 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
2177 \$750,000 or greater.

2178 (3) This section does not apply to contracts entered into by the department or a  
2179 division, board, or council of the department if:

2180 (a) the application of this section jeopardizes the receipt of federal funds;

2181 (b) the contract or agreement is between:

2182 (i) the department or a division, board, or council of the department; and

2183 (ii) (A) another agency of the state;

2184 (B) the federal government;

2185 (C) another state;

2186 (D) an interstate agency;

2187 (E) a political subdivision of this state; or

2188 (F) a political subdivision of another state; or

2189 (c) the contract or agreement is:

2190 (i) for the purpose of disbursing grants or loans authorized by statute;

2191 (ii) a sole source contract; or

2192 (iii) an emergency procurement.

2193 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),  
2194 or a modification to a contract, when the contract does not meet the initial threshold required  
2195 by Subsection (2).

2196 (b) A person who intentionally uses change orders or contract modifications to  
2197 circumvent the requirements of Subsection (2) is guilty of an infraction.

2198 (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department  
2199 that the contractor has and will maintain an offer of qualified health insurance coverage for the  
2200 contractor's employees and the employees' dependents during the duration of the contract.

2201 (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor  
2202 shall demonstrate to the department that the subcontractor has and will maintain an offer of  
2203 qualified health insurance coverage for the subcontractor's employees and the employees'  
2204 dependents during the duration of the contract.

2205 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during  
2206 the duration of the contract is subject to penalties in accordance with administrative rules  
2207 adopted by the department under Subsection (6).

2208 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
2209 requirements of Subsection (5)(b).

2210 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
2211 the duration of the contract is subject to penalties in accordance with administrative rules  
2212 adopted by the department under Subsection (6).

2213 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
2214 requirements of Subsection (5)(a).

2215 (6) The department shall adopt administrative rules:

2216 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2217 (b) in coordination with:

2218 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

2219 (ii) a public transit district in accordance with Section [17B-2a-818.5](#);

2220 (iii) the State Building Board in accordance with Section [63A-5-205](#);

2221 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

2222 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

2223 (vi) the Legislature's Administrative Rules Review Committee; and

2224 (c) which establish:

2225 (i) the requirements and procedures a contractor must follow to demonstrate

2226 compliance with this section to the department which shall include:



2227 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or  
2228 (b) more than twice in any 12-month period; and

2229 (B) that the actuarially equivalent determination required for qualified health insurance  
2230 coverage in Subsection (1) is met by the contractor if the contractor provides the department or  
2231 division with a written statement of actuarial equivalency from either:

2232 (I) the Utah Insurance Department;

2233 (II) an actuary selected by the contractor or the contractor's insurer; or

2234 (III) an underwriter who is responsible for developing the employer group's premium  
2235 rates;

2236 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
2237 violates the provisions of this section, which may include:

2238 (A) a three-month suspension of the contractor or subcontractor from entering into  
2239 future contracts with the state upon the first violation;

2240 (B) a six-month suspension of the contractor or subcontractor from entering into future  
2241 contracts with the state upon the second violation;

2242 (C) an action for debarment of the contractor or subcontractor in accordance with  
2243 Section [63G-6a-904](#) upon the third or subsequent violation; and

2244 (D) monetary penalties which may not exceed 50% of the amount necessary to  
2245 purchase qualified health insurance coverage for an employee and a dependent of an employee  
2246 of the contractor or subcontractor who was not offered qualified health insurance coverage  
2247 during the duration of the contract; and

2248 (iii) a website on which the department shall post the benchmark for the qualified  
2249 health insurance coverage identified in Subsection (1)(c).

2250 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or  
2251 subcontractor who intentionally violates the provisions of this section shall be liable to the  
2252 employee for health care costs that would have been covered by qualified health insurance  
2253 coverage.

2254 (ii) An employer has an affirmative defense to a cause of action under Subsection  
2255 (7)(a)(i) if:

2256 (A) the employer relied in good faith on a written statement of actuarial equivalency  
2257 provided by:

2258 (I) an actuary; or  
2259 (II) an underwriter who is responsible for developing the employer group's premium  
2260 rates; or

2261 (B) the department determines that compliance with this section is not required under  
2262 the provisions of Subsection (3) or (4).

2263 (b) An employee has a private right of action only against the employee's employer to  
2264 enforce the provisions of this Subsection (7).

2265 (8) Any penalties imposed and collected under this section shall be deposited into the  
2266 Medicaid Restricted Account created in Section [26-18-402](#).

2267 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
2268 coverage as required by this section:

2269 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
2270 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah  
2271 Procurement Code; and

2272 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
2273 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
2274 or construction.

2275 Section 33. **Effective date.**

2276 (1) Except as provided in Subsection (2), this bill takes effect May 13, 2014.

2277 (2) The amendments to Section [63I-1-231](#) (Effective 07/01/14) take effect on July 1,  
2278 2014.

2279 Section 34. **Coordinating H.B. 141 with H.B. 24 -- Superseding technical and**  
2280 **substantive amendments.**

2281 If this H.B. 141 and H.B. 24, Insurance Related Amendments, both pass and become  
2282 law, it is the intent of the Legislature that the amendments to Sections [31A-23b-205](#) and  
2283 [31A-23b-206](#) in this bill, supersede the amendments to Sections [31A-23b-205](#) and  
2284 [31A-23b-206](#) in H.B. 24, when the Office of Legislative Research and General Counsel  
2285 prepares the Utah Code database for publication.

2286 Section 35. **Coordinating H.B. 141 with H.B. 35 -- Superseding technical and**  
2287 **substantive amendments.**

2288 If this H.B. 141 and H.B. 35, Reauthorization of Health Data Authority Act, both pass

2289 and become law, it is the intent of the Legislature that the amendments to Section [26-33a-106.1](#)  
2290 in this bill, supersede the amendments to Section [26-33a-106.1](#) in H.B. 35, when the Office of  
2291 Legislative Research and General Counsel prepares the Utah Code database for publication.