1 # HEALTH REFORM AMENDMENTS

2 2014 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: Allen M. Christensen

6

7 **LONG TITLE**

8 **General Description:**

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

10 reform.

11 **Highlighted Provisions:**

12 This bill:

13 ▸ amends the period of time in which an employee of a state contractor must be

14 enrolled in health insurance to conform to federal law;

15 ▸ amends the Utah Health Data Authority Act to facilitate:

16 • the coordination of eligibility for health insurance benefits; and

17 • cost and quality reports for episodes of care;

18 ▸ amends the health insurance navigator license chapter of the Insurance Code to:

19 • create two types of navigator licenses;

20 • establish different training for the types of licenses; and

21 • add an exception to the license requirement for Indian health centers;

22 ▸ amends the state Comprehensive Health Insurance Pool to:

23 • close the pool to new enrollees;

24 • pay out claims incurred by enrollees; and

25 • close down the business of the pool;

26 ▸ permits an enrollee to re-new an insurance plan as long as permitted by federal

27 policy;

28 ▸ establishes the state option for calculating the cost to the state if the state mandates

29 additional benefits to the PPACA essential health benefits;

30 ▸ creates the Individual and Small Employer Risk Adjustment Act, which:
31 • requires the insurance commissioner to work with stakeholders to develop a
32 state based risk adjustment program for the individual and small group market;
33 • describes the risk adjustment models the commissioner may consider;
34 • requires the commissioner to report to the Legislature before implementing a
35 risk adjustment model;
36 • authorizes the commissioner to set fees for the operation of the risk adjustment
37 program; and
38 • establishes an Individual and Small Employer Risk Adjustment Enterprise Fund
39 for the operation of the program;
40 ▸ requires the Office of Consumer Health Services, which runs the small employer
41 health insurance exchange, to provide the form required for the federal small
42 employer premium tax credit to small employers who purchase qualified health
43 plans; and
44 ▸ makes technical and conforming amendments.
45 **Money Appropriated in this Bill:**
46 None
47 **Other Special Clauses:**
48 This bill provides an effective date.
49 This bill coordinates with H.B. 24, Insurance Related Amendments, by providing
50 superseding and substantive amendments.
51 This bill coordinates with H.B. 35, Reauthorization of Utah Health Data Authority Act,
52 by providing superseding and substantive amendments.
53 **Utah Code Sections Affected:**
54 AMENDS:
55 **17B-2a-818.5**, as last amended by Laws of Utah 2012, Chapter 347
56 **19-1-206**, as last amended by Laws of Utah 2012, Chapter 347
57 **26-33a-106.1**, as last amended by Laws of Utah 2012, Chapter 279

58 **26-33a-106.5**, as last amended by Laws of Utah 2012, Chapter 279
59 **26-33a-109**, as last amended by Laws of Utah 2010, Chapter 68
60 **31A-4-115**, as last amended by Laws of Utah 2002, Chapter 308
61 **31A-8-402.3**, as last amended by Laws of Utah 2004, Chapter 329
62 **31A-22-721**, as last amended by Laws of Utah 2011, Chapter 284
63 **31A-23b-205**, as enacted by Laws of Utah 2013, Chapter 341
64 **31A-23b-206**, as enacted by Laws of Utah 2013, Chapter 341
65 **31A-23b-211**, as enacted by Laws of Utah 2013, Chapter 341
66 **31A-29-106**, as last amended by Laws of Utah 2013, Chapter 319
67 **31A-29-110**, as last amended by Laws of Utah 2012, Chapter 347
68 **31A-29-111**, as last amended by Laws of Utah 2012, Chapters 158 and 347
69 **31A-29-113**, as last amended by Laws of Utah 2013, Chapter 319
70 **31A-29-114**, as last amended by Laws of Utah 2006, Chapter 95
71 **31A-29-115**, as last amended by Laws of Utah 2004, Chapter 2
72 **31A-30-103**, as last amended by Laws of Utah 2013, Chapter 168
73 **31A-30-107**, as last amended by Laws of Utah 2009, Chapter 12
74 **31A-30-108**, as last amended by Laws of Utah 2011, Chapter 284
75 **31A-30-117**, as enacted by Laws of Utah 2013, Chapter 341
76 **63A-5-205**, as last amended by Laws of Utah 2012, Chapter 347
77 **63C-9-403**, as last amended by Laws of Utah 2012, Chapter 347
78 **63I-1-231** **(Effective 07/01/14)**, as last amended by Laws of Utah 2013, Chapters 261
79 and 417
80 **63M-1-2504**, as last amended by Laws of Utah 2013, Chapter 255
81 **72-6-107.5**, as last amended by Laws of Utah 2012, Chapter 347
82 **79-2-404**, as last amended by Laws of Utah 2012, Chapter 347
83 ENACTS:
84 **31A-23b-202.5**, Utah Code Annotated 1953
85 **31A-30-118**, Utah Code Annotated 1953

86 **31A-30-301**, Utah Code Annotated 1953
87 **31A-30-302**, Utah Code Annotated 1953
88 **31A-30-303**, Utah Code Annotated 1953
89 **Utah Code Sections Affected by Coordination Clause:**
90 **26-33a-106.1**, as last amended by Laws of Utah 2012, Chapter 279
91 **31A-23b-205**, as enacted by Laws of Utah 2013, Chapter 341
92 **31A-23b-206**, as enacted by Laws of Utah 2013, Chapter 341
93

94 *Be it enacted by the Legislature of the state of Utah:*
95 Section 1. Section **17B-2a-818.5** is amended to read:
96 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**
97 **coverage.**
98 (1) For purposes of this section:
99 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
100 34A-2-104 who:
101 (i) works at least 30 hours per calendar week; and
102 (ii) meets employer eligibility waiting requirements for health care insurance which
103 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
104 hire.
105 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
106 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.
107 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
108 (2) (a) Except as provided in Subsection (3), this section applies to a design or
109 construction contract entered into by the public transit district on or after July 1, 2009, and to a
110 prime contractor or to a subcontractor in accordance with Subsection (2)(b).
111 (b) (i) A prime contractor is subject to this section if the prime contract is in the
112 amount of $1,500,000 or greater.
113 (ii) A subcontractor is subject to this section if a subcontract is in the amount of

114 $750,000 or greater.
115 (3) This section does not apply if:
116 (a) the application of this section jeopardizes the receipt of federal funds;
117 (b) the contract is a sole source contract; or
118 (c) the contract is an emergency procurement.
119 (4) (a) This section does not apply to a change order as defined in Section 63G-6a-103,
120 or a modification to a contract, when the contract does not meet the initial threshold required
121 by Subsection (2).
122 (b) A person who intentionally uses change orders or contract modifications to
123 circumvent the requirements of Subsection (2) is guilty of an infraction.
124 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit
125 district that the contractor has and will maintain an offer of qualified health insurance coverage
126 for the contractor's employees and the employee's dependents during the duration of the
127 contract.
128 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
129 shall demonstrate to the public transit district that the subcontractor has and will maintain an
130 offer of qualified health insurance coverage for the subcontractor's employees and the
131 employee's dependents during the duration of the contract.
132 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
133 the duration of the contract is subject to penalties in accordance with an ordinance adopted by
134 the public transit district under Subsection (6).
135 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
136 requirements of Subsection (5)(b).
137 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
138 the duration of the contract is subject to penalties in accordance with an ordinance adopted by
139 the public transit district under Subsection (6).
140 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
141 requirements of Subsection (5)(a).

142 (6) The public transit district shall adopt ordinances:
143 (a) in coordination with:
144 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
145 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
146 (iii) the State Building Board in accordance with Section 63A-5-205;
147 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and
148 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
149 (b) which establish:
150 (i) the requirements and procedures a contractor shall follow to demonstrate to the
151 public transit district compliance with this section which shall include:
152 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
153 (b) more than twice in any 12-month period; and
154 (B) that the actuarially equivalent determination required for the qualified health
155 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
156 department or division with a written statement of actuarial equivalency from either:
157 (I) the Utah Insurance Department;
158 (II) an actuary selected by the contractor or the contractor's insurer; or
159 (III) an underwriter who is responsible for developing the employer group's premium
160 rates;
161 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
162 violates the provisions of this section, which may include:
163 (A) a three-month suspension of the contractor or subcontractor from entering into
164 future contracts with the public transit district upon the first violation;
165 (B) a six-month suspension of the contractor or subcontractor from entering into future
166 contracts with the public transit district upon the second violation;
167 (C) an action for debarment of the contractor or subcontractor in accordance with
168 Section 63G-6a-904 upon the third or subsequent violation; and
169 (D) monetary penalties which may not exceed 50% of the amount necessary to

170 purchase qualified health insurance coverage for employees and dependents of employees of
171 the contractor or subcontractor who were not offered qualified health insurance coverage
172 during the duration of the contract; and
173 (iii) a website on which the district shall post the benchmark for the qualified health
174 insurance coverage identified in Subsection (1)(c).
175 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor
176 or subcontractor who intentionally violates the provisions of this section shall be liable to the
177 employee for health care costs that would have been covered by qualified health insurance
178 coverage.
179 (ii) An employer has an affirmative defense to a cause of action under Subsection
180 (7)(a)(i) if:
181 (A) the employer relied in good faith on a written statement of actuarial equivalency
182 provided by an:
183 (I) actuary; or
184 (II) underwriter who is responsible for developing the employer group's premium rates;
185 or
186 (B) a department or division determines that compliance with this section is not
187 required under the provisions of Subsection (3) or (4).
188 (b) An employee has a private right of action only against the employee's employer to
189 enforce the provisions of this Subsection (7).
190 (8) Any penalties imposed and collected under this section shall be deposited into the
191 Medicaid Restricted Account created in Section 26-18-402.
192 (9) The failure of a contractor or subcontractor to provide qualified health insurance
193 coverage as required by this section:
194 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
195 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
196 Procurement Code; and
197 (b) may not be used by the procurement entity or a prospective bidder, offeror, or

198 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
199 or construction.
200 Section 2. Section **19-1-206** is amended to read:
201 **19-1-206. Contracting powers of department -- Health insurance coverage.**
202 (1) For purposes of this section:
203 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
204 34A-2-104 who:
205 (i) works at least 30 hours per calendar week; and
206 (ii) meets employer eligibility waiting requirements for health care insurance which
207 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
208 hire.
209 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
210 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.
211 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
212 (2) (a) Except as provided in Subsection (3), this section applies to a design or
213 construction contract entered into by or delegated to the department or a division or board of
214 the department on or after July 1, 2009, and to a prime contractor or subcontractor in
215 accordance with Subsection (2)(b).
216 (b) (i) A prime contractor is subject to this section if the prime contract is in the
217 amount of $1,500,000 or greater.
218 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
219 $750,000 or greater.
220 (3) This section does not apply to contracts entered into by the department or a division
221 or board of the department if:
222 (a) the application of this section jeopardizes the receipt of federal funds;
223 (b) the contract or agreement is between:
224 (i) the department or a division or board of the department; and
225 (ii) (A) another agency of the state;

226 (B) the federal government;
227 (C) another state;
228 (D) an interstate agency;
229 (E) a political subdivision of this state; or
230 (F) a political subdivision of another state;
231 (c) the executive director determines that applying the requirements of this section to a
232 particular contract interferes with the effective response to an immediate health and safety
233 threat from the environment; or
234 (d) the contract is:
235 (i) a sole source contract; or
236 (ii) an emergency procurement.
237 (4) (a) This section does not apply to a change order as defined in Section 63G-6a-103,
238 or a modification to a contract, when the contract does not meet the initial threshold required
239 by Subsection (2).
240 (b) A person who intentionally uses change orders or contract modifications to
241 circumvent the requirements of Subsection (2) is guilty of an infraction.
242 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
243 director that the contractor has and will maintain an offer of qualified health insurance
244 coverage for the contractor's employees and the employees' dependents during the duration of
245 the contract.
246 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
247 demonstrate to the executive director that the subcontractor has and will maintain an offer of
248 qualified health insurance coverage for the subcontractor's employees and the employees'
249 dependents during the duration of the contract.
250 (c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration
251 of the contract is subject to penalties in accordance with administrative rules adopted by the
252 department under Subsection (6).
253 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the

254 requirements of Subsection (5)(b).
255 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
256 the duration of the contract is subject to penalties in accordance with administrative rules
257 adopted by the department under Subsection (6).
258 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
259 requirements of Subsection (5)(a).
260 (6) The department shall adopt administrative rules:
261 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
262 (b) in coordination with:
263 (i) a public transit district in accordance with Section 17B-2a-818.5;
264 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
265 (iii) the State Building Board in accordance with Section 63A-5-205;
266 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
267 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
268 (vi) the Legislature's Administrative Rules Review Committee; and
269 (c) which establish:
270 (i) the requirements and procedures a contractor shall follow to demonstrate to the
271 public transit district compliance with this section that shall include:
272 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
273 (b) more than twice in any 12-month period; and
274 (B) that the actuarially equivalent determination required for the qualified health
275 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
276 department or division with a written statement of actuarial equivalency from either:
277 (I) the Utah Insurance Department;
278 (II) an actuary selected by the contractor or the contractor's insurer; or
279 (III) an underwriter who is responsible for developing the employer group's premium
280 rates;
281 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

282 violates the provisions of this section, which may include:
283 (A) a three-month suspension of the contractor or subcontractor from entering into
284 future contracts with the state upon the first violation;
285 (B) a six-month suspension of the contractor or subcontractor from entering into future
286 contracts with the state upon the second violation;
287 (C) an action for debarment of the contractor or subcontractor in accordance with
288 Section 63G-6a-904 upon the third or subsequent violation; and
289 (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%
290 of the amount necessary to purchase qualified health insurance coverage for an employee and
291 the dependents of an employee of the contractor or subcontractor who was not offered qualified
292 health insurance coverage during the duration of the contract; and
293 (iii) a website on which the department shall post the benchmark for the qualified
294 health insurance coverage identified in Subsection (1)(c).
295 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
296 subcontractor who intentionally violates the provisions of this section shall be liable to the
297 employee for health care costs that would have been covered by qualified health insurance
298 coverage.
299 (ii) An employer has an affirmative defense to a cause of action under Subsection
300 (7)(a)(i) if:
301 (A) the employer relied in good faith on a written statement of actuarial equivalency
302 provided by:
303 (I) an actuary; or
304 (II) an underwriter who is responsible for developing the employer group's premium
305 rates; or
306 (B) the department determines that compliance with this section is not required under
307 the provisions of Subsection (3) or (4).
308 (b) An employee has a private right of action only against the employee's employer to
309 enforce the provisions of this Subsection (7).

310 (8) Any penalties imposed and collected under this section shall be deposited into the
311 Medicaid Restricted Account created in Section 26-18-402.
312 (9) The failure of a contractor or subcontractor to provide qualified health insurance
313 coverage as required by this section:
314 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
315 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
316 Procurement Code; and
317 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
318 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
319 or construction.
320 Section 3. Section **26-33a-106.1** is amended to read:
321 **26-33a-106.1. Health care cost and reimbursement data.**
322 [~~(1) (a) The committee shall, as funding is available, establish an advisory panel to~~
323 ~~advise the committee on the development of a plan for the collection and use of health care~~
324 ~~data pursuant to Subsection 26-33a-104(6) and this section.~~]
325 [~~(b) The advisory panel shall include:~~]
326 [~~(i) the chairman of the Utah Hospital Association;~~]
327 [~~(ii) a representative of a rural hospital as designated by the Utah Hospital~~
328 ~~Association;~~]
329 [~~(iii) a representative of the Utah Medical Association;~~]
330 [~~(iv) a physician from a small group practice as designated by the Utah Medical~~
331 ~~Association;~~]
332 [~~(v) two representatives who are health insurers, appointed by the committee;~~]
333 [~~(vi) a representative from the Department of Health as designated by the executive~~
334 ~~director of the department;~~]
335 [~~(vii) a representative from the committee;~~]
336 [~~(viii) a consumer advocate appointed by the committee;~~]
337 [~~(ix) a member of the House of Representatives appointed by the speaker of the House;~~

338 ~~and~~]

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

340 [~~(c) The advisory panel shall elect a chair from among its members, and shall be~~

341 ~~staffed by the committee.~~]

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

343 [~~(i)~~] (a) establish a plan for collecting data from data suppliers, as defined in Section

344 26-33a-102, to determine measurements of cost and reimbursements for risk-adjusted episodes

345 of health care;

346 [~~(ii)~~] (b) share data regarding insurance claims and an individual's and small employer

347 group's health risk factor and characteristics of insurance arrangements that affect claims and

348 usage with [~~insurers participating in the defined contribution market created in Title 31A,~~

349 ~~Chapter 30, Part 2, Defined Contribution Arrangements~~] the Insurance Department, only to the

350 extent necessary for:

351 (i) risk adjusting; and

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

353 [~~(A) establishing rates and prospective risk adjusting in the defined contribution~~

354 ~~arrangement market; and~~]

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

356 [~~(iii)~~] (c) assist the Legislature and the public with awareness of, and the promotion of,

357 transparency in the health care market by reporting on:

358 [~~(A)~~] (i) geographic variances in medical care and costs as demonstrated by data

359 available to the committee; and

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

361 [~~(I)~~] (A) that exceed the Consumer Price Index - Medical as provided by the United

362 States Bureau of Labor Statistics;

363 [~~(II)~~] (B) as calculated yearly from June to June; and

364 [~~(III)~~] (C) as demonstrated by data available to the committee[~~.~~]; and

365 (d) provide on at least a monthly basis, enrollment data collected by the committee to a

366 not-for-profit, broad-based coalition of state health care insurers and health care providers that
367 are involved in the standardized electronic exchange of health data as described in Section
368 31A-22-614.5, to the extent necessary:
369 (i) for the department or the Medicaid Office of the Inspector General to determine
370 insurance enrollment of an individual for the purpose of determining Medicaid third party
371 liability;
372 (ii) for an insurer that is a data supplier, to determine insurance enrollment of an
373 individual for the purpose of coordination of health care benefits; and
374 (iii) for a health care provider, to determine insurance enrollment for a patient for the
375 purpose of claims submission by the health care provider.
376 (2) (a) The Medicaid Office of Inspector General shall annually report to the
377 Legislature's Health and Human Services Interim Committee regarding how the office used the
378 data obtained under Subsection (1)(d)(i) and the results of obtaining the data.
379 (b) A data supplier shall not be liable for a breach of or unlawful disclosure of the data
380 obtained by an entity described in Subsection (1)(b).
381 [(b)] (3) The plan adopted under [this] Subsection [(2)] (1) shall include:
382 [(i)] (a) the type of data that will be collected;
383 [(ii)] (b) how the data will be evaluated;
384 [(iii)] (c) how the data will be used;
385 [(iv)] (d) the extent to which, and how the data will be protected; and
386 [(v)] (e) who will have access to the data.
387 Section 4. Section **26-33a-106.5** is amended to read:
388 **26-33a-106.5. Comparative analyses.**
389 (1) The committee may publish compilations or reports that compare and identify
390 health care providers or data suppliers from the data it collects under this chapter or from any
391 other source.
392 (2) (a) [The] Except as provided in Subsection (7)(c), the committee shall publish
393 compilations or reports from the data it collects under this chapter or from any other source

394 which:

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

396 (ii) compare and identify by name at least a majority of the health care facilities, health

397 care plans, and institutions in the state.

398 (b) [~~The~~] Except as provided in Subsection (7)(c), the report required by this

399 Subsection (2) shall:

400 (i) be published at least annually; and

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

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

403 (B) charges; and

404 (C) nationally recognized patient safety standards.

405 (3) The committee may contract with a private, independent analyst to evaluate the

406 standard comparative reports of the committee that identify, compare, or rank the performance

407 of data suppliers by name. The evaluation shall include a validation of statistical

408 methodologies, limitations, appropriateness of use, and comparisons using standard health

409 services research practice. The analyst shall be experienced in analyzing large databases from

410 multiple data suppliers and in evaluating health care issues of cost, quality, and access. The

411 results of the analyst's evaluation shall be released to the public before the standard

412 comparative analysis upon which it is based may be published by the committee.

413 (4) The committee shall adopt by rule a timetable for the collection and analysis of data

414 from multiple types of data suppliers.

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

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

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

418 (6) (a) The department shall include in the report required by Subsection (2)(b), or

419 include in a separate report, comparative information on commonly recognized or generally

420 agreed upon measures of cost and quality identified in accordance with Subsection (7), for:

421 (i) routine and preventive care; and

422 (ii) the treatment of diabetes, heart disease, and other illnesses or conditions as
423 determined by the committee.
424 (b) The comparative information required by Subsection (6)(a) shall be based on data
425 collected under Subsection (2) and clinical data that may be available to the committee, and
426 shall [beginning on or after July 1, 2012,] compare:
427 (i) beginning December 31, 2014, results for health care facilities or institutions;
428 (ii) beginning December 31, 2014, results for health care providers by geographic
429 regions of the state;
430 [(ii)] (iii) beginning July 1, 2016, a clinic's aggregate results for a physician who
431 practices at a clinic with five or more physicians; and
432 [(iii)] (iv) beginning July 1, 2016, a geographic region's aggregate results for a
433 physician who practices at a clinic with less than five physicians, unless the physician requests
434 physician-level data to be published on a clinic level.
435 (c) The department:
436 (i) may publish information required by this Subsection (6) directly or through one or
437 more nonprofit, community-based health data organizations;
438 (ii) may use a private, independent analyst under Subsection (3) in preparing the report
439 required by this section; and
440 (iii) shall identify and report to the Legislature's Health and Human Services Interim
441 Committee by July 1, [2012] 2014, and every July 1[,] thereafter until July 1, [2015, at least
442 five] 2019, at least three new measures of quality to be added to the report each year.
443 (d) A report published by the department under this Subsection (6):
444 (i) is subject to the requirements of Section 26-33a-107; and
445 (ii) shall, prior to being published by the department, be submitted to a neutral,
446 non-biased entity with a broad base of support from health care payers and health care
447 providers in accordance with Subsection (7) for the purpose of validating the report.
448 (7) (a) The Health Data Committee shall, through the department, for purposes of
449 Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral,

450 non-biased entity with a broad base of support from health care payers and health care
451 providers.
452 (b) If the entity described in Subsection (7)(a) does not submit the quality measures,
453 the department may select the appropriate number of quality measures for purposes of the
454 report required by Subsection (6).
455 (c) (i) For purposes of the reports published on or after July 1, [2012] 2014, the
456 department may not compare individual facilities or clinics as described in Subsections
457 (6)(b)(i) through [(iii)] (iv) if the department determines that the data available to the
458 department can not be appropriately validated, does not represent nationally recognized
459 measures, does not reflect the mix of cases seen at a clinic or facility, or is not sufficient for the
460 purposes of comparing providers.
461 (ii) The department shall report to the Legislature's Executive Appropriations
462 Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).
463 Section 5. Section **26-33a-109** is amended to read:
464 **26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.**
465 (1) The committee may not disclose any identifiable health data unless:
466 (a) the individual has authorized the disclosure; or
467 (b) the disclosure complies with the provisions of:
468 (i) this section[.];
469 (ii) insurance enrollment and coordination of benefits under Subsection
470 26-33a-106.1(1)(d); or
471 (iii) risk adjusting under Subsection 26-33a-106.1(1)(b).
472 (2) The committee shall consider the following when responding to a request for
473 disclosure of information that may include identifiable health data:
474 (a) whether the request comes from a person after that person has received approval to
475 do the specific research and statistical work from an institutional review board; and
476 (b) whether the requesting entity complies with the provisions of Subsection (3).
477 (3) A request for disclosure of information that may include identifiable health data

478 shall:
479 (a) be for a specified period; or
480 (b) be solely for bona fide research and statistical purposes as determined in
481 accordance with administrative rules adopted by the department, which shall require:
482 (i) the requesting entity to demonstrate to the department that the data is required for
483 the research and statistical purposes proposed by the requesting entity; and
484 (ii) the requesting entity to enter into a written agreement satisfactory to the department
485 to protect the data in accordance with this chapter or other applicable law.
486 (4) A person accessing identifiable health data pursuant to Subsection (3) may not
487 further disclose the identifiable health data:
488 (a) without prior approval of the department; and
489 (b) unless the identifiable health data is disclosed or identified by control number only.
490 Section 6. Section **31A-4-115** is amended to read:
491 **31A-4-115. Plan of orderly withdrawal.**
492 (1) (a) When an insurer intends to withdraw from writing a line of insurance in this
493 state or to reduce its total annual premium volume by 75% or more, the insurer shall file with
494 the commissioner a plan of orderly withdrawal.
495 (b) For purposes of this section, a discontinuance of a health benefit plan pursuant to
496 one of the following provisions is a withdrawal from a line of insurance:
497 (i) Subsection 31A-30-107(3)(e); or
498 (ii) Subsection 31A-30-107.1(3)(e).
499 (2) An insurer's plan of orderly withdrawal shall:
500 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and
501 (b) include provisions for:
502 (i) meeting the insurer's contractual obligations;
503 (ii) providing services to its Utah policyholders and claimants;
504 (iii) meeting any applicable statutory obligations; and
505 (iv) (A) the payment of a withdrawal fee of $50,000 to the Utah Comprehensive Health

506 Insurance Pool if:
507 (I) the insurer is an accident and health insurer; and
508 (II) the insurer's line of business is not assumed or placed with another insurer
509 approved by the commissioner; or
510 (B) the payment of a withdrawal fee of $50,000 to the department if:
511 (I) the insurer is not an accident and health insurer; and
512 (II) the insurer's line of business is not assumed or placed with another insurer
513 approved by the commissioner.
514 (3) The commissioner shall approve a plan of orderly withdrawal if the plan adequately
515 demonstrates that the insurer will:
516 (a) protect the interests of the people of the state;
517 (b) meet the insurer's contractual obligations;
518 (c) provide service to the insurer's Utah policyholders and claimants; and
519 (d) meet any applicable statutory obligations.
520 (4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for
521 orderly withdrawal.
522 (5) The commissioner may require an insurer to increase the deposit maintained in
523 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in
524 the name of the commissioner upon finding, after an adjudicative proceeding that:
525 (a) there is reasonable cause to conclude that the interests of the people of the state are
526 best served by such action; and
527 (b) the insurer:
528 (i) has filed a plan of orderly withdrawal; or
529 (ii) intends to:
530 (A) withdraw from writing a line of insurance in this state; or
531 (B) reduce the insurer's total annual premium volume by 75% or more.
532 (6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:
533 (a) withdraws from writing insurance in this state; or

534 (b) reduces its total annual premium volume by 75% or more in any year without
535 having submitted a plan or receiving the commissioner's approval.
536 (7) An insurer that withdraws from writing all lines of insurance in this state may not
537 resume writing insurance in this state for five years unless[: (a)] the commissioner finds that
538 the prohibition should be waived because the waiver is:
539 [(i)] (a) in the public interest to promote competition; or
540 [(ii)] (b) to resolve inequity in the marketplace[; and].
541 [(b) the insurer complies with Subsection 31A-30-108(5), if applicable.]
542 (8) The commissioner shall adopt rules necessary to implement this section.
543 Section 7. Section **31A-8-402.3** is amended to read:
544 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
545 **plans.**
546 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
547 sponsor is renewable and continues in force:
548 (a) with respect to all eligible employees and dependents; and
549 (b) at the option of the plan sponsor.
550 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed[: (a)]
551 for a network plan, if:
552 [(i)] (a) there is no longer any enrollee under the group health plan who lives, resides,
553 or works in:
554 [(A)] (i) the service area of the insurer; or
555 [(B)] (ii) the area for which the insurer is authorized to do business; [and] or
556 [(ii) in the case of the small employer market, the insurer applies the same criteria the
557 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or]
558 (b) for coverage made available in the small or large employer market only through an
559 association, if:
560 (i) the employer's membership in the association ceases; and
561 (ii) the coverage is terminated uniformly without regard to any health status-related

562 factor relating to any covered individual.
563 (3) A health benefit plan for a plan sponsor may be discontinued if:
564 (a) a condition described in Subsection (2) exists;
565 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
566 terms of the contract;
567 (c) the plan sponsor:
568 (i) performs an act or practice that constitutes fraud; or
569 (ii) makes an intentional misrepresentation of material fact under the terms of the
570 coverage;
571 (d) the insurer:
572 (i) elects to discontinue offering a particular health benefit product delivered or issued
573 for delivery in this state; and
574 (ii) (A) provides notice of the discontinuation in writing:
575 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
576 (II) at least 90 days before the date the coverage will be discontinued;
577 (B) provides notice of the discontinuation in writing:
578 (I) to the commissioner; and
579 (II) at least three working days prior to the date the notice is sent to the affected plan
580 sponsors, employees, and dependents of the plan sponsors or employees;
581 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
582 (I) all other health benefit products currently being offered by the insurer in the market;
583 or
584 (II) in the case of a large employer, any other health benefit product currently being
585 offered in that market; and
586 (D) in exercising the option to discontinue that product and in offering the option of
587 coverage in this section, acts uniformly without regard to:
588 (I) the claims experience of a plan sponsor;
589 (II) any health status-related factor relating to any covered participant or beneficiary; or

590 (III) any health status-related factor relating to any new participant or beneficiary who
591 may become eligible for the coverage; or
592 (e) the insurer:
593 (i) elects to discontinue all of the insurer's health benefit plans in:
594 (A) the small employer market;
595 (B) the large employer market; or
596 (C) both the small employer and large employer markets; and
597 (ii) (A) provides notice of the discontinuation in writing:
598 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
599 (II) at least 180 days before the date the coverage will be discontinued;
600 (B) provides notice of the discontinuation in writing:
601 (I) to the commissioner in each state in which an affected insured individual is known
602 to reside; and
603 (II) at least 30 working days prior to the date the notice is sent to the affected plan
604 sponsors, employees, and the dependents of the plan sponsors or employees;
605 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
606 market; and
607 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
608 (4) A large employer health benefit plan may be discontinued or nonrenewed:
609 (a) if a condition described in Subsection (2) exists; or
610 (b) for noncompliance with the insurer's:
611 (i) minimum participation requirements; or
612 (ii) employer contribution requirements.
613 (5) A small employer health benefit plan may be discontinued or nonrenewed:
614 (a) if a condition described in Subsection (2) exists; or
615 (b) for noncompliance with the insurer's employer contribution requirements.
616 (6) A small employer health benefit plan may be nonrenewed:
617 (a) if a condition described in Subsection (2) exists; or

618 (b) for noncompliance with the insurer's minimum participation requirements.
619 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
620 discontinued if after issuance of coverage the eligible employee:
621 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
622 or
623 (ii) makes an intentional misrepresentation of material fact in connection with the
624 coverage.
625 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
626 (i) 12 months after the date of discontinuance; and
627 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
628 to reenroll.
629 (c) At the time the eligible employee's coverage is discontinued under Subsection
630 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
631 discontinued.
632 (d) An eligible employee may not be discontinued under this Subsection (7) because of
633 a fraud or misrepresentation that relates to health status.
634 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
635 the employer:
636 (a) with respect to coverage provided to an employer member of the association; and
637 (b) if the health benefit plan is made available by an insurer in the employer market
638 only through:
639 (i) an association;
640 (ii) a trust; or
641 (iii) a discretionary group.
642 (9) An insurer may modify a health benefit plan for a plan sponsor only:
643 (a) at the time of coverage renewal; and
644 (b) if the modification is effective uniformly among all plans with that product.
645 Section 8. Section **31A-22-721** is amended to read:

646 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
647 **nonrenewal.**
648 (1) Except as otherwise provided in this section, a health benefit plan for a plan
649 sponsor is renewable and continues in force:
650 (a) with respect to all eligible employees and dependents; and
651 (b) at the option of the plan sponsor.
652 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed[~~: (a)~~]
653 for a network plan, if:
654 [~~(i)~~] (a) there is no longer any enrollee under the group health plan who lives, resides,
655 or works in:
656 [~~(A)~~] (i) the service area of the insurer; or
657 [~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or
658 [~~(ii) in the case of the small employer market, the insurer applies the same criteria the~~
659 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]
660 (b) for coverage made available in the small or large employer market only through an
661 association, if:
662 (i) the employer's membership in the association ceases; and
663 (ii) the coverage is terminated uniformly without regard to any health status-related
664 factor relating to any covered individual.
665 (3) A health benefit plan for a plan sponsor may be discontinued if:
666 (a) a condition described in Subsection (2) exists;
667 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
668 terms of the contract;
669 (c) the plan sponsor:
670 (i) performs an act or practice that constitutes fraud; or
671 (ii) makes an intentional misrepresentation of material fact under the terms of the
672 coverage;
673 (d) the insurer:

674 (i) elects to discontinue offering a particular health benefit product delivered or issued
675 for delivery in this state;
676 (ii) (A) provides notice of the discontinuation in writing:
677 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
678 (II) at least 90 days before the date the coverage will be discontinued;
679 (B) provides notice of the discontinuation in writing:
680 (I) to the commissioner; and
681 (II) at least three working days prior to the date the notice is sent to the affected plan
682 sponsors, employees, and dependents of plan sponsors or employees;
683 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
684 other health benefit products currently being offered:
685 (I) by the insurer in the market; or
686 (II) in the case of a large employer, any other health benefit plan currently being
687 offered in that market; and
688 (D) in exercising the option to discontinue that product and in offering the option of
689 coverage in this section, the insurer acts uniformly without regard to:
690 (I) the claims experience of a plan sponsor;
691 (II) any health status-related factor relating to any covered participant or beneficiary; or
692 (III) any health status-related factor relating to a new participant or beneficiary who
693 may become eligible for coverage; or
694 (e) the insurer:
695 (i) elects to discontinue all of the insurer's health benefit plans:
696 (A) in the small employer market; or
697 (B) the large employer market; or
698 (C) both the small and large employer markets; and
699 (ii) (A) provides notice of the discontinuance in writing:
700 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
701 (II) at least 180 days before the date the coverage will be discontinued;

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

730 to reenroll.

731 (c) At the time the eligible employee's coverage is discontinued under Subsection
732 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
733 discontinued.

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

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

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

742 (i) to promote competition; or

743 (ii) to resolve inequity in the marketplace.

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

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

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

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

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

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

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

755 (i) an association;

756 (ii) a trust; or

757 (iii) a discretionary group.

758 (12) (a) A small employer that, after purchasing a health benefit plan in the small group
759 market, employs on average more than 50 eligible employees on each business day in a
760 calendar year may continue to renew the health benefit plan purchased in the small group
761 market.
762 (b) A large employer that, after purchasing a health benefit plan in the large group
763 market, employs on average less than 51 eligible employees on each business day in a calendar
764 year may continue to renew the health benefit plan purchased in the large group market.
765 (13) An insurer offering employer sponsored health benefit plans shall comply with the
766 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.
767 Section 9. Section **31A-23b-202.5** is enacted to read:
768 **31A-23b-202.5. License types.**
769 (1) A license issued under this chapter shall be issued under the license types described
770 in Subsection (2).
771 (2) A license type under this chapter shall be a navigator line of authority or a certified
772 application counselor line of authority. A license type is intended to describe the matters to be
773 considered under any education, examination, and training required of an applicant under this
774 chapter.
775 (3) (a) A navigator line of authority includes the enrollment process as described in
776 Subsection 31A-23b-102(4)(a).
777 (b) (i) A certified application counselor line of authority is limited to providing
778 information and assistance to individuals and employees about public programs and premium
779 subsidies available through the exchange.
780 (ii) A certified application counselor line of authority does not allow the certified
781 application counselor to assist a person with the selection of or enrollment in a qualified health
782 plan offered on an exchange.
783 Section 10. Section **31A-23b-205** is amended to read:
784 **31A-23b-205. Examination and training requirements.**
785 (1) The commissioner may require [~~applicants~~] an applicant for a license to pass an

786 examination and complete a training program as a requirement for a license.
787 (2) The examination described in Subsection (1) shall reasonably relate to:
788 (a) the duties and functions of a navigator;
789 (b) requirements for navigators as established by federal regulation under PPACA; and
790 (c) other requirements that may be established by the commissioner by administrative
791 rule.
792 (3) The examination may be administered by the commissioner or as otherwise
793 specified by administrative rule.
794 (4) The training required by Subsection (1) shall be approved by the commissioner and
795 shall include:
796 (a) accident and health insurance plans;
797 (b) qualifications for and enrollment in public programs;
798 (c) qualifications for and enrollment in premium subsidies;
799 (d) cultural and linguistic competence;
800 (e) conflict of interest standards;
801 (f) exchange functions; and
802 (g) other requirements that may be adopted by the commissioner by administrative
803 rule.
804 (5) (a) For the navigator line of authority, the training required by Subsection (1) shall
805 consist of at least 21 credit hours of training before obtaining the license, which shall include:
806 (i) at least two hours of training on defined contribution arrangements and the small
807 employer health insurance exchange; and
808 (ii) the navigator training and certification program developed by the Centers for
809 Medicare and Medicaid Services.
810 (b) For the certified application counselor line of authority, the training required by
811 Subsection (1) shall consist of at least six hours of training before obtaining a license, which
812 shall include:
813 (i) at least one hour of training on defined contribution arrangements and the small

814 employer health insurance exchange; and
815 (ii) the certified application counselor training and certification program developed by
816 the Centers for Medicare and Medicaid Services.
817 [(5)] (6) This section applies only to [applicants who are natural persons] an applicant
818 who is a natural person.
819 Section 11. Section **31A-23b-206** is amended to read:
820 **31A-23b-206. Continuing education requirements.**
821 (1) The commissioner shall, by rule, prescribe continuing education requirements for a
822 navigator.
823 (2) (a) The commissioner may not require a degree from an institution of higher
824 education as part of continuing education.
825 (b) The commissioner may state a continuing education requirement in terms of hours
826 of instruction received in:
827 (i) accident and health insurance;
828 (ii) qualification for and enrollment in public programs;
829 (iii) qualification for and enrollment in premium subsidies;
830 (iv) cultural competency;
831 (v) conflict of interest standards; and
832 (vi) other exchange functions.
833 (3) (a) [Continuing] For a navigator line of authority, continuing education
834 requirements shall require:
835 (i) that a licensee complete [24] 12 credit hours of continuing education for every
836 [two-year] one-year licensing period;
837 (ii) that [3] at least two of the [24] 12 credit hours described in Subsection (3)(a)(i) be
838 ethics courses; [and]
839 [(iii) that the licensee complete at least half of the required hours through classroom
840 hours of insurance and exchange related instruction.]
841 (iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training

842 on defined contribution arrangements and the use of the small employer health insurance
843 exchange; and
844 (iv) that a licensee complete the annual navigator training and certification program
845 developed by the Centers for Medicare and Medicaid Services.
846 (b) For a certified application counselor, the continuing education requirements shall
847 require:
848 (i) that a licensee complete six credit hours of continuing education for every one-year
849 licensing period;
850 (ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on
851 ethics courses;
852 (iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be training
853 on defined contribution arrangements and the use of the small employer health insurance
854 exchange; and
855 (iv) that a licensee complete the annual certified application counselor training and
856 certification program developed by the Centers for Medicare and Medicaid Services.
857 [~~(b)~~] (c) An hour of continuing education in accordance with [~~Subsection~~] Subsections
858 (3)(a)(i) and (b)(i) may be obtained through:
859 (i) classroom attendance;
860 (ii) home study;
861 (iii) watching a video recording; or
862 [~~(iv) experience credit; or~~]
863 [~~(v)~~] (iv) another method approved by rule.
864 [~~(c)~~] (d) A licensee may obtain continuing education hours at any time during the
865 [~~two-year~~] one-year license period.
866 [~~(d)~~] (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
867 Act, the commissioner shall, by rule[~~: (i) publish a list of insurance professional designations~~
868 ~~whose continuing education requirements can be used to meet the requirements for continuing~~
869 ~~education under Subsection (3)(b); and (ii)~~], authorize one or more continuing education

870 providers, including a state or national professional producer or consultant associations, to:
871 [(A)] (i) offer a qualified program on a geographically accessible basis; and
872 [(B)] (ii) collect a reasonable fee for funding and administration of a continuing
873 education program, subject to the review and approval of the commissioner.
874 (4) The commissioner shall approve a continuing education provider or a continuing
875 education course that satisfies the requirements of this section.
876 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
877 commissioner shall by rule establish the procedures for continuing education provider
878 registration and course approval.
879 (6) This section applies only to a navigator who is a natural person.
880 (7) A navigator shall keep documentation of completing the continuing education
881 requirements of this section for two years after the end of the two-year licensing period to
882 which the continuing education applies.
883 Section 12. Section **31A-23b-211** is amended to read:
884 **31A-23b-211. Exceptions to navigator licensing.**
885 (1) For purposes of this section:
886 (a) "Negotiate" is as defined in Section 31A-23a-102.
887 (b) "Sell" is as defined in Section 31A-23a-102.
888 (c) "Solicit" is as defined in Section 31A-23a-102.
889 (2) The commissioner may not require a license as a navigator of:
890 (a) a person who is employed by or contracts with:
891 (i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility
892 Licensing and Inspection Act, to assist an individual with enrollment in a public program or an
893 application for premium subsidy; or
894 (ii) the state, a political subdivision of the state, an entity of a political subdivision of
895 the state, or a public school district to assist an individual with enrollment in a public program
896 or an application for premium subsidy;
897 (b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social

898 Security Act which assists an individual with enrollment in a public program or an application
899 for premium subsidy;
900 (c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants,
901 and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to
902 sell, solicit, or negotiate accident and health insurance plans;
903 (d) an officer, director, or employee of a navigator:
904 (i) who does not receive compensation or commission from an insurer issuing an
905 insurance contract, an agency administering a public program, an individual who enrolled in a
906 public program or insurance product, or an exchange; and
907 (ii) whose activities:
908 (A) are executive, administrative, managerial, clerical, or a combination thereof;
909 (B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the
910 enrollment in a public program offered through the exchange;
911 (C) are in the capacity of a special agent or agency supervisor assisting an insurance
912 producer or navigator;
913 (D) are limited to providing technical advice and assistance to a licensed insurance
914 producer or navigator; or
915 (E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment
916 in a public program; [~~and~~]
917 (e) a person who does not sell, solicit, or negotiate insurance and is not directly or
918 indirectly compensated by an insurer issuing an insurance contract, an agency administering a
919 public program, an individual who enrolled in a public program or insurance product, or an
920 exchange, including:
921 (i) an employer, association, officer, director, employee, or trustee of an employee trust
922 plan who is engaged in the administration or operation of a program:
923 (A) of employee benefits for the employer's or association's own employees or the
924 employees of a subsidiary or affiliate of an employer or association; and
925 (B) that involves the use of insurance issued by an insurer or enrollment in a public

926 health plan on an exchange;
927 (ii) an employee of an insurer or organization employed by an insurer who is engaging
928 in the inspection, rating, or classification of risk, or the supervision of training of insurance
929 producers; or
930 (iii) an employee who counsels or advises the employee's employer with regard to the
931 insurance interests of the employer, or a subsidiary or business affiliate of the employer[.]; and
932 (f) an Indian health clinic or Urban Indian Health Center, as defined in Title V of the
933 Indian Health Care Improvement Act, which assists a person with enrollment in a public
934 program or an application for a premium subsidy.
935 (3) The exemption from licensure under Subsections (2)(a) [and], (b), and (f) does not
936 apply if a person described in Subsections (2)(a) [and], (b), and (f) enrolls a person in a private
937 insurance plan.
938 (4) The commissioner may by rule exempt a class of persons from the license
939 requirement of Subsection 31A-23b-201(1) if:
940 (a) the functions performed by the class of persons do not require:
941 (i) special competence;
942 (ii) special trustworthiness; or
943 (iii) regulatory surveillance made possible by licensing; or
944 (b) other existing safeguards make regulation unnecessary.
945 Section 13. Section **31A-29-106** is amended to read:
946 **31A-29-106. Powers of board.**
947 (1) The board shall have the general powers and authority granted under the laws of
948 this state to insurance companies licensed to transact health care insurance business. In
949 addition, the board shall [have the specific authority to]:
950 (a) have the specific authority to enter into contracts to carry out the provisions and
951 purposes of this chapter, including, with the approval of the commissioner, contracts with:
952 (i) similar pools of other states for the joint performance of common administrative
953 functions; or

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

982 preferred provider organizations, and other managed care systems that will manage costs while
983 maintaining quality care;]
984 [(k)] (i) establish annual limits on benefits payable under the pool to or on behalf of
985 any enrollee;
986 [(l)] (j) exclude from coverage under the pool specific benefits, medical conditions,
987 and procedures for the purpose of protecting the financial viability of the pool;
988 [(m)] (k) administer the Pool Fund;
989 [(n)] (l) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
990 Rulemaking Act, to implement this chapter;
991 [(o)] (m) adopt, trademark, and copyright a trade name for the pool for use in
992 marketing and publicizing the pool and its products; and
993 [(p)] (n) transition health care coverage for all individuals covered under the pool as
994 part of the conversion to health insurance coverage, regardless of preexisting conditions, under
995 PPACA.
996 (2) (a) The board shall prepare and submit an annual and final report to the Legislature
997 which shall include:
998 (i) the net premiums anticipated;
999 (ii) actuarial projections of payments required of the pool;
1000 (iii) the expenses of administration; and
1001 (iv) the anticipated reserves or losses of the pool.
1002 (b) The budget for operation of the pool is subject to the approval of the board.
1003 (c) The administrative budget of the board and the commissioner under this chapter
1004 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
1005 subject to review and approval by the Legislature.
1006 [(3) (a) The board shall on or before September 1, 2004, require the plan administrator
1007 or an independent actuarial consultant retained by the plan administrator to redetermine the
1008 reasonable equivalent of the criteria for uninsurability required under Subsection
1009 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]

1010 [(b) The board shall redetermine the criteria established in Subsection (3)(a) at least
1011 every five years thereafter.]
1012 Section 14. Section **31A-29-110** is amended to read:
1013 **31A-29-110. Pool administrator -- Selection -- Powers.**
1014 (1) The board shall select a pool administrator in accordance with Title 63G, Chapter
1015 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the
1016 board, which shall include:
1017 (a) ability to manage medical expenses;
1018 (b) proven ability to handle accident and health insurance;
1019 (c) efficiency of claim paying procedures;
1020 (d) marketing and underwriting;
1021 (e) proven ability for managed care and quality assurance;
1022 (f) provider contracting and discounts;
1023 (g) pharmacy benefit management;
1024 (h) an estimate of total charges for administering the pool; and
1025 (i) ability to administer the pool in a cost-efficient manner.
1026 (2) A pool administrator may be:
1027 (a) a health insurer;
1028 (b) a health maintenance organization;
1029 (c) a third-party administrator; or
1030 (d) any person or entity which has demonstrated ability to meet the criteria in
1031 Subsection (1).
1032 (3) [(a)] The pool administrator shall serve for a period of three years, with [two
1033 one-year] yearly extension options until the operations of the pool are closed pursuant to
1034 Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract
1035 between the board and the administrator.
1036 [(b) At least one year prior to the expiration of the contract between the board and the
1037 pool administrator, the board shall invite all interested parties, including the current pool

1038 administrator, to submit bids to serve as the pool administrator].

1039 [(c) Selection of the pool administrator for a succeeding period shall be made at least

1040 six months prior to the expiration of the period of service under Subsection (3)(a).]

1041 (4) The pool administrator is responsible for all operational functions of the pool and

1042 shall:

1043 (a) have access to all nonpatient specific experience data, statistics, treatment criteria,

1044 and guidelines compiled or adopted by the Medicaid program, the Public Employees Health

1045 Plan, the Department of Health, or the Insurance Department, and which are not otherwise

1046 declared by statute to be confidential;

1047 (b) perform all marketing, eligibility, enrollment, member agreements, and

1048 administrative claim payment functions relating to the pool;

1049 (c) establish, administer, and operate a monthly premium billing procedure for

1050 collection of premiums from enrollees;

1051 (d) perform all necessary functions to assure timely payment of benefits to enrollees,

1052 including:

1053 (i) making information available relating to the proper manner of submitting a claim

1054 for benefits to the pool administrator and distributing forms upon which submission shall be

1055 made; and

1056 (ii) evaluating the eligibility of each claim for payment by the pool;

1057 (e) submit regular reports to the board regarding the operation of the pool, the

1058 frequency, content, and form of which reports shall be determined by the board;

1059 (f) following the close of each calendar year, determine net written and earned

1060 premiums, the expense of administration, and the paid and incurred losses for the year and

1061 submit a report of this information to the board, the commissioner, and the Division of Finance

1062 on a form prescribed by the commissioner; and

1063 (g) be paid as provided in the plan of operation for expenses incurred in the

1064 performance of the pool administrator's services.

1065 Section 15. Section **31A-29-111** is amended to read:

1066 **31A-29-111. Eligibility -- Limitations.**

1067 (1) (a) Except as provided in Subsection (1)(b) and Subsection 31A-29-106(1)(d), an
1068 individual who is not HIPAA eligible is eligible for pool coverage if the individual:
1069 (i) pays the established premium;
1070 (ii) is a resident of this state; and
1071 (iii) meets the health underwriting criteria under Subsection (5)(a).
1072 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not
1073 eligible for pool coverage if one or more of the following conditions apply:
1074 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
1075 except as provided in Section 31A-29-112;
1076 (ii) the individual has terminated coverage in the pool, unless:
1077 (A) 12 months have elapsed since the termination date; or
1078 (B) the individual demonstrates that creditable coverage has been involuntarily
1079 terminated for any reason other than nonpayment of premium;
1080 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
1081 (iv) the individual is an inmate of a public institution;
1082 (v) the individual is eligible for a public health plan, as defined in federal regulations
1083 adopted pursuant to 42 U.S.C. 300gg;
1084 (vi) the individual's health condition does not meet the criteria established under
1085 Subsection (5);
1086 (vii) the individual is eligible for coverage under an employer group that offers a health
1087 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members
1088 as:
1089 (A) an eligible employee;
1090 (B) a dependent of an eligible employee; or
1091 (C) a member;
1092 (viii) the individual is covered under any other health benefit plan;
1093 (ix) except as provided in Subsections (3) and (6), at the time of application, the

1094 individual has not resided in Utah for at least 12 consecutive months preceding the date of
1095 application; or
1096 (x) the individual's employer pays any part of the individual's health benefit plan
1097 premium, either as an insured or a dependent, for pool coverage.
1098 (2) (a) Except as provided in Subsection (2)(b) and Subsection 31A-29-106(1)(d), an
1099 individual who is HIPAA eligible is eligible for pool coverage if the individual:
1100 (i) pays the established premium; and
1101 (ii) is a resident of this state.
1102 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for
1103 pool coverage if one or more of the following conditions apply:
1104 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
1105 except as provided in Section 31A-29-112;
1106 (ii) the individual is eligible for a public health plan, as defined in federal regulations
1107 adopted pursuant to 42 U.S.C. 300gg;
1108 (iii) the individual is covered under any other health benefit plan;
1109 (iv) the individual is eligible for coverage under an employer group that offers a health
1110 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members
1111 as:
1112 (A) an eligible employee;
1113 (B) a dependent of an eligible employee; or
1114 (C) a member;
1115 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
1116 (vi) the individual is an inmate of a public institution; or
1117 (vii) the individual's employer pays any part of the individual's health benefit plan
1118 premium, either as an insured or a dependent, for pool coverage.
1119 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
1120 (1)(a), an individual whose health care insurance coverage from a state high risk pool with
1121 similar coverage is terminated because of nonresidency in another state is eligible for coverage

1122 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).
1123 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the
1124 termination date of the previous high risk pool coverage.
1125 (c) The effective date of this state's pool coverage shall be the date of termination of
1126 the previous high risk pool coverage.
1127 (d) The waiting period of an individual with a preexisting condition applying for
1128 coverage under this chapter shall be waived:
1129 (i) to the extent to which the waiting period was satisfied under a similar plan from
1130 another state; and
1131 (ii) if the other state's benefit limitation was not reached.
1132 (4) (a) If an eligible individual applies for pool coverage within 30 days of being
1133 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
1134 than the first day of the month following the date of submission of the completed insurance
1135 application to the carrier.
1136 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
1137 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
1138 coverage.
1139 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
1140 based on:
1141 (i) health condition; and
1142 (ii) expected claims so that the expected claims are anticipated to remain within
1143 available funding.
1144 (b) The board, with approval of the commissioner, may contract with one or more
1145 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting
1146 criteria under Subsection (5)(a).
1147 (c) If an individual is denied coverage by the pool under the criteria established in
1148 Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage
1149 under [~~Subsection~~] Section 31A-30-108[~~(3)~~].

1150 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
1151 (1)(a), an individual whose individual health care insurance coverage was involuntarily
1152 terminated, is eligible for coverage under the pool subject to the conditions of Subsections
1153 (1)(b)(i) through (viii) and (x).
1154 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the
1155 termination date of the previous individual health care insurance coverage.
1156 (c) The effective date of this state's pool coverage shall be the date of termination of
1157 the previous individual coverage.
1158 (d) The waiting period of an individual with a preexisting condition applying for
1159 coverage under this chapter shall be waived to the extent to which the waiting period was
1160 satisfied under the individual health insurance plan.
1161 Section 16. Section **31A-29-113** is amended to read:
1162 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**
1163 **conditions -- Waiver -- Maximum benefits.**
1164 (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished
1165 for the diagnoses or treatment of illness or injury that:
1166 (i) exceed the deductible and copayment amounts applicable under Section
1167 31A-29-114; and
1168 (ii) are not otherwise limited or excluded.
1169 (b) Eligible medical expenses are the allowed charges established by the board for the
1170 health care services and items rendered during times for which benefits are extended under the
1171 pool policy.
1172 (c) Section 31A-21-313 applies to coverage issued under this chapter.
1173 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and
1174 other limitations shall be established by the board.
1175 (3) The commissioner shall approve the benefit package developed by the board to
1176 ensure its compliance with this chapter.
1177 [~~(4) The pool shall offer at least one benefit plan through a managed care program as~~

1178 authorized under Section 31A-29-106.]

1179 [(5)] (4) This chapter may not be construed to prohibit the pool from issuing additional
1180 types of pool policies with different types of benefits which in the opinion of the board may be
1181 of benefit to the citizens of Utah.

1182 [(6)] (5) (a) The board shall design and require an administrator to employ cost
1183 containment measures and requirements including preadmission certification and concurrent
1184 inpatient review for the purpose of making the pool more cost effective.

1185 (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this
1186 chapter.

1187 [(7)] (6) (a) A pool policy may contain provisions under which coverage for a
1188 preexisting condition is excluded if:

1189 (i) the exclusion relates to a condition, regardless of the cause of the condition, for
1190 which medical advice, diagnosis, care, or treatment was recommended or received, from an
1191 individual licensed or similarly authorized to provide such services under state law and
1192 operating within the scope of practice authorized by state law, within the six-month period
1193 ending on the effective date of plan coverage; and

1194 (ii) except as provided in Subsection (8), the exclusion extends for a period no longer
1195 than the six-month period following the effective date of plan coverage for a given individual.

1196 (b) Subsection [(7)] (6)(a) does not apply to a HIPAA eligible individual.

1197 [(8)] (7) (a) A pool policy may contain provisions under which coverage for a
1198 preexisting pregnancy is excluded during a ten-month period following the effective date of
1199 plan coverage for a given individual.

1200 (b) Subsection [(8)] (7)(a) does not apply to a HIPAA eligible individual.

1201 [(9)] (8) (a) The pool will waive the preexisting condition exclusion described in
1202 Subsections [(7)] (6)(a) and [(8)] (7)(a) for an individual that is changing health coverage to the
1203 pool, to the extent to which similar exclusions have been satisfied under any prior health
1204 insurance coverage if the individual applies not later than 63 days following the date of
1205 involuntary termination, other than for nonpayment of premiums, from health coverage.

1206 (b) If this Subsection [(9)] (8) applies, coverage in the pool shall be effective from the
1207 date on which the prior coverage was terminated.
1208 [(10)] (9) Covered benefits available from the pool may not exceed a $1,800,000
1209 lifetime maximum, which includes a per enrollee calendar year maximum established by the
1210 board.
1211 Section 17. Section **31A-29-114** is amended to read:
1212 **31A-29-114. Deductibles -- Copayments.**
1213 (1) (a) A pool policy shall impose a deductible on a per calendar year basis.
1214 (b) At least two deductible plans shall be offered.
1215 (c) The deductible is applied to all of the eligible medical expenses [as defined in
1216 Section 31A-29-113,] incurred by the enrollee until the deductible has been satisfied. There
1217 are no benefits payable before the deductible has been satisfied.
1218 (d) The pool may offer separate deductibles for prescription benefits.
1219 (2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least
1220 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess
1221 of the mandatory deductible.
1222 (b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool
1223 policy.
1224 (3) The board shall establish maximum aggregate out-of-pocket payments for eligible
1225 medical expenses incurred by the enrollee for each of the deductible plans offered under
1226 Subsection (1)(b).
1227 (4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments
1228 under Subsection (3), the board may establish a coinsurance requirement to be imposed on
1229 eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.
1230 (b) The circumstances in which the coinsurance authorized by this Subsection (4) may
1231 be imposed shall be designated in the pool policy.
1232 (c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to
1233 exceed 5% of eligible medical expenses.

1234 (5) The limits on maximum aggregate out-of-pocket payments for eligible medical
1235 expenses incurred by the enrollee under this section may not include out-of-pocket payments
1236 for prescription benefits.

1237 Section 18. Section **31A-29-115** is amended to read:

1238 **31A-29-115. Cancellation -- Notice.**

1239 (1) [~~(a)~~] On the date of renewal, the pool may cancel an enrollee's policy if:
1240 [~~(i)~~] (a) the enrollee's health condition does not meet the criteria established in
1241 Subsection 31A-29-111(5); and
1242 [~~(ii)~~] (b) the pool has provided written notice to the enrollee's last-known address no
1243 less than 60 days before cancellation[~~; and~~].
1244 [~~(iii) at least one individual carrier has not reached the individual enrollment cap~~
1245 ~~established in Section 31A-30-110.~~]
1246 [~~(b) The pool shall issue a certificate of insurability to an enrollee whose policy is~~
1247 ~~cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the~~
1248 ~~requirements of Subsection 31A-29-111(5) are met.~~]
1249 (2) The pool may cancel an enrollee's policy at any time if:
1250 (a) the pool has provided written notice to the enrollee's last-known address no less
1251 than 15 days before cancellation; and
1252 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
1253 months;
1254 (ii) there is nonpayment of premiums; or
1255 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
1256 forth in Section 31A-29-111, in which case:
1257 (A) the policy may be retroactively terminated for the period of time in which the
1258 enrollee was not eligible;
1259 (B) retroactive termination may not exceed three years; and
1260 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
1261 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection

1262 31A-29-119(3).

1263 Section 19. Section **31A-30-103** is amended to read:

1264 **31A-30-103. Definitions.**

1265 As used in this chapter:

1266 (1) "Actuarial certification" means a written statement by a member of the American
1267 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
1268 is in compliance with Sections 31A-30-106 and 31A-30-106.1, based upon the examination of
1269 the covered carrier, including review of the appropriate records and of the actuarial
1270 assumptions and methods used by the covered carrier in establishing premium rates for
1271 applicable health benefit plans.

1272 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
1273 through one or more intermediaries, controls or is controlled by, or is under common control
1274 with, a specified entity or person.

1275 (3) "Base premium rate" means, for each class of business as to a rating period, the
1276 lowest premium rate charged or that could have been charged under a rating system for that
1277 class of business by the covered carrier to covered insureds with similar case characteristics for
1278 health benefit plans with the same or similar coverage.

1279 (4) (a) "Bona fide employer association" means an association of employers:

1280 (i) that meets the requirements of Subsection 31A-22-701(2)(b);

1281 (ii) in which the employers of the association, either directly or indirectly, exercise
1282 control over the plan;

1283 (iii) that is organized:

1284 (A) based on a commonality of interest between the employers and their employees
1285 that participate in the plan by some common economic or representation interest or genuine
1286 organizational relationship unrelated to the provision of benefits; and

1287 (B) to act in the best interests of its employers to provide benefits for the employer's
1288 employees and their spouses and dependents, and other benefits relating to employment; and

1289 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

1290 (b) The commissioner shall consider the following with regard to determining whether
1291 an association of employers is a bona fide employer association under Subsection (4)(a):
1292 (i) how association members are solicited;
1293 (ii) who participates in the association;
1294 (iii) the process by which the association was formed;
1295 (iv) the purposes for which the association was formed, and what, if any, were the
1296 pre-existing relationships of its members;
1297 (v) the powers, rights and privileges of employer members; and
1298 (vi) who actually controls and directs the activities and operations of the benefit
1299 programs.
1300 (5) "Carrier" means any person or entity that provides health insurance in this state
1301 including:
1302 (a) an insurance company;
1303 (b) a prepaid hospital or medical care plan;
1304 (c) a health maintenance organization;
1305 (d) a multiple employer welfare arrangement; and
1306 (e) any other person or entity providing a health insurance plan under this title.
1307 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
1308 demographic or other objective characteristics of a covered insured that are considered by the
1309 carrier in determining premium rates for the covered insured.
1310 (b) "Case characteristics" do not include:
1311 (i) duration of coverage since the policy was issued;
1312 (ii) claim experience; and
1313 (iii) health status.
1314 (7) "Class of business" means all or a separate grouping of covered insureds that is
1315 permitted by the commissioner in accordance with Section 31A-30-105.
1316 (8) "Conversion policy" means a policy providing coverage under the conversion
1317 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

1318 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
1319 this chapter.
1320 (10) "Covered individual" means any individual who is covered under a health benefit
1321 plan subject to this chapter.
1322 (11) "Covered insureds" means small employers and individuals who are issued a
1323 health benefit plan that is subject to this chapter.
1324 (12) "Dependent" means an individual to the extent that the individual is defined to be
1325 a dependent by:
1326 (a) the health benefit plan covering the covered individual; and
1327 (b) Chapter 22, Part 6, Accident and Health Insurance.
1328 (13) "Established geographic service area" means a geographical area approved by the
1329 commissioner within which the carrier is authorized to provide coverage.
1330 (14) "Index rate" means, for each class of business as to a rating period for covered
1331 insureds with similar case characteristics, the arithmetic average of the applicable base
1332 premium rate and the corresponding highest premium rate.
1333 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
1334 through a health benefit plan regardless of whether:
1335 (a) coverage is offered through:
1336 (i) an association;
1337 (ii) a trust;
1338 (iii) a discretionary group; or
1339 (iv) other similar groups; or
1340 (b) the policy or contract is situated out-of-state.
1341 (16) "Individual conversion policy" means a conversion policy issued to:
1342 (a) an individual; or
1343 (b) an individual with a family.
1344 (17) "Individual coverage count" means the number of natural persons covered under a
1345 carrier's health benefit products that are individual policies.

1346 (18) "Individual enrollment cap" means the percentage set by the commissioner in
1347 accordance with Section 31A-30-110.
1348 (19) "New business premium rate" means, for each class of business as to a rating
1349 period, the lowest premium rate charged or offered, or that could have been charged or offered,
1350 by the carrier to covered insureds with similar case characteristics for newly issued health
1351 benefit plans with the same or similar coverage.
1352 (20) "Premium" means money paid by covered insureds and covered individuals as a
1353 condition of receiving coverage from a covered carrier, including any fees or other
1354 contributions associated with the health benefit plan.
1355 (21) (a) "Rating period" means the calendar period for which premium rates
1356 established by a covered carrier are assumed to be in effect, as determined by the carrier.
1357 (b) A covered carrier may not have:
1358 (i) more than one rating period in any calendar month; and
1359 (ii) no more than 12 rating periods in any calendar year.
1360 (22) "Resident" means an individual who has resided in this state for at least 12
1361 consecutive months immediately preceding the date of application.
1362 (23) "Short-term limited duration insurance" means a health benefit product that:
1363 (a) is not renewable; and
1364 (b) has an expiration date specified in the contract that is less than 364 days after the
1365 date the plan became effective.
1366 (24) "Small employer carrier" means a carrier that provides health benefit plans
1367 covering eligible employees of one or more small employers in this state, regardless of
1368 whether:
1369 (a) coverage is offered through:
1370 (i) an association;
1371 (ii) a trust;
1372 (iii) a discretionary group; or
1373 (iv) other similar grouping; or

1374 (b) the policy or contract is situated out-of-state.
1375 [(25) "Uninsurable" means an individual who:]
1376 [(a) is eligible for the Comprehensive Health Insurance Pool coverage under the
1377 underwriting criteria established in Subsection 31A-29-111(5); or]
1378 [(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and]
1379 [(ii) has a condition of health that does not meet consistently applied underwriting
1380 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g)
1381 and (h) for which coverage the applicant is applying.]
1382 [(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
1383 purposes of this formula:]
1384 [(a) "CI" means the carrier's individual coverage count as of December 31 of the
1385 preceding year; and]
1386 [(b) "UC" means the number of uninsurable individuals who were issued an individual
1387 policy on or after July 1, 1997.]
1388 Section 20. Section **31A-30-107** is amended to read:
1389 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
1390 **nonrenewal.**
1391 (1) Except as otherwise provided in this section, a small employer health benefit plan is
1392 renewable and continues in force:
1393 (a) with respect to all eligible employees and dependents; and
1394 (b) at the option of the plan sponsor.
1395 (2) A small employer health benefit plan may be discontinued or nonrenewed:
1396 (a) for a network plan, if[: (i)] there is no longer any enrollee under the group health
1397 plan who lives, resides, or works in:
1398 [(A)] (i) the service area of the covered carrier; or
1399 [(B)] (ii) the area for which the covered carrier is authorized to do business; [and] or
1400 [(ii) in the case of the small employer market, the small employer carrier applies the
1401 same criteria the small employer carrier would apply in denying enrollment in the plan under

1402 ~~Subsection 31A-30-108(7); or~~]
1403 (b) for coverage made available in the small or large employer market only through an
1404 association, if:
1405 (i) the employer's membership in the association ceases; and
1406 (ii) the coverage is terminated uniformly without regard to any health status-related
1407 factor relating to any covered individual.
1408 (3) A small employer health benefit plan may be discontinued if:
1409 (a) a condition described in Subsection (2) exists;
1410 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
1411 premiums or contributions in accordance with the terms of the contract;
1412 (c) the plan sponsor:
1413 (i) performs an act or practice that constitutes fraud; or
1414 (ii) makes an intentional misrepresentation of material fact under the terms of the
1415 coverage;
1416 (d) the covered carrier:
1417 (i) elects to discontinue offering a particular small employer health benefit product
1418 delivered or issued for delivery in this state; and
1419 (ii) (A) provides notice of the discontinuation in writing:
1420 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1421 (II) at least 90 days before the date the coverage will be discontinued;
1422 (B) provides notice of the discontinuation in writing:
1423 (I) to the commissioner; and
1424 (II) at least three working days prior to the date the notice is sent to the affected plan
1425 sponsors, employees, and dependents of the plan sponsors or employees;
1426 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
1427 other small employer health benefit products currently being offered by the small employer
1428 carrier in the market; and
1429 (D) in exercising the option to discontinue that product and in offering the option of

1430 coverage in this section, acts uniformly without regard to:
1431 (I) the claims experience of a plan sponsor;
1432 (II) any health status-related factor relating to any covered participant or beneficiary; or
1433 (III) any health status-related factor relating to any new participant or beneficiary who
1434 may become eligible for the coverage; or
1435 (e) the covered carrier:
1436 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
1437 in:
1438 (A) the small employer market;
1439 (B) the large employer market; or
1440 (C) both the small employer and large employer markets; and
1441 (ii) (A) provides notice of the discontinuation in writing:
1442 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1443 (II) at least 180 days before the date the coverage will be discontinued;
1444 (B) provides notice of the discontinuation in writing:
1445 (I) to the commissioner in each state in which an affected insured individual is known
1446 to reside; and
1447 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1448 sponsors, employees, and the dependents of the plan sponsors or employees;
1449 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1450 market; and
1451 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
1452 (4) A small employer health benefit plan may be discontinued or nonrenewed:
1453 (a) if a condition described in Subsection (2) exists; or
1454 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1455 employer contribution requirements.
1456 (5) A small employer health benefit plan may be nonrenewed:
1457 (a) if a condition described in Subsection (2) exists; or

1458 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1459 minimum participation requirements.
1460 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
1461 discontinued if after issuance of coverage the eligible employee:
1462 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
1463 or
1464 (ii) makes an intentional misrepresentation of material fact in connection with the
1465 coverage.
1466 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
1467 (i) 12 months after the date of discontinuance; and
1468 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1469 to reenroll.
1470 (c) At the time the eligible employee's coverage is discontinued under Subsection
1471 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
1472 coverage is discontinued.
1473 (d) An eligible employee may not be discontinued under this Subsection (6) because of
1474 a fraud or misrepresentation that relates to health status.
1475 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
1476 the employer:
1477 (a) with respect to coverage provided to an employer member of the association; and
1478 (b) if the small employer health benefit plan is made available by a covered carrier in
1479 the employer market only through:
1480 (i) an association;
1481 (ii) a trust; or
1482 (iii) a discretionary group.
1483 (8) A covered carrier may modify a small employer health benefit plan only:
1484 (a) at the time of coverage renewal; and
1485 (b) if the modification is effective uniformly among all plans with that product.

1486 Section 21. Section **31A-30-108** is amended to read:

1487 **31A-30-108. Eligibility for small employer and individual market.**

1488 (1) (a) [~~Small employer carriers shall accept residents~~] A small employer carrier shall

1489 accept a small employer that applies for small group coverage as set forth in the Health

1490 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a) and PPACA, Sec. 2702.

1491 [~~(b) Individual carriers shall accept residents for individual coverage pursuant to:~~]

1492 [~~(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and~~]

1493 [~~(ii) Subsection (3).~~]

1494 (b) An individual carrier shall accept an individual that applies for individual coverage

1495 as set forth in PPACA, Sec. 2702.

1496 (2) (a) [~~Small~~] A small employer [~~carriers~~] carrier shall offer to accept all eligible

1497 employees and their dependents at the same level of benefits under any health benefit plan

1498 provided to a small employer.

1499 (b) [~~Small~~] A small employer [~~carriers~~] carrier may:

1500 (i) request a small employer to submit a copy of the small employer's quarterly income

1501 tax withholdings to determine whether the employees for whom coverage is provided or

1502 requested are bona fide employees of the small employer; and

1503 (ii) deny or terminate coverage if the small employer refuses to provide documentation

1504 requested under Subsection (2)(b)(i).

1505 [~~(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~

1506 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:~~]

1507 [~~(a) the individual is not covered or eligible for coverage:~~]

1508 [~~(i) (A) as an employee of an employer;~~]

1509 [~~(B) as a member of an association; or~~]

1510 [~~(C) as a member of any other group; and~~]

1511 [~~(ii) under:~~]

1512 [~~(A) a health benefit plan; or~~]

1513 [~~(B) a self-insured arrangement that provides coverage similar to that provided by a~~

1514 health benefit plan as defined in Section 31A-1-301;]
1515 [(b) the individual is not covered and is not eligible for coverage under any public
1516 health benefits arrangement including:]
1517 [(i) the Medicare program established under Title XVIII of the Social Security Act;]
1518 [(ii) any act of Congress or law of this or any other state that provides benefits
1519 comparable to the benefits provided under this chapter; or]
1520 [(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter
1521 29, Comprehensive Health Insurance Pool Act;]
1522 [(c) unless the maximum benefit has been reached the individual is not covered or
1523 eligible for coverage under any:]
1524 [(i) Medicare supplement policy;]
1525 [(ii) conversion option;]
1526 [(iii) continuation or extension under COBRA; or]
1527 [(iv) state extension;]
1528 [(d) the individual has not terminated or declined coverage described in Subsection
1529 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for
1530 individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),
1531 in which case, the requirement of this Subsection (3)(d) does not apply; and]
1532 [(e) the individual is certified as ineligible for the Health Insurance Pool if:]
1533 [(i) the individual applies for coverage with the Comprehensive Health Insurance Pool
1534 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for
1535 coverage with that covered carrier within 30 days after the date of issuance of a certificate
1536 under Subsection 31A-29-111(5)(c); or]
1537 [(ii) the individual applies for coverage with any individual carrier within 45 days
1538 after:]
1539 [(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or]
1540 [(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the
1541 individual applied first for coverage with the Comprehensive Health Insurance Pool.]

1542 [(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is
1543 paid, the effective date of coverage shall be the first day of the month following the individual's
1544 submission of a completed insurance application to that covered carrier.]
1545 [(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is
1546 paid, the effective date of coverage shall be the day following the:]
1547 [(i) cancellation of coverage under Subsection 31A-29-115(1); or]
1548 [(ii) submission of a completed insurance application to the Comprehensive Health
1549 Insurance Pool].
1550 [(5) (a) An individual carrier is not required to accept individuals for coverage under
1551 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]
1552 [(b) A carrier described in Subsection (5)(a) may not issue new individual policies in
1553 the state for five years from July 1, 1997.]
1554 [(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new
1555 policies after July 1, 1999, which may only be granted if:]
1556 [(i) the carrier accepts uninsurables as is required of a carrier entering the market under
1557 Subsection 31A-30-110; and]
1558 [(ii) the commissioner finds that the carrier's issuance of new individual policies:]
1559 [(A) is in the best interests of the state; and]
1560 [(B) does not provide an unfair advantage to the carrier.]
1561 [(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29,
1562 Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is
1563 capped or suspended, an individual carrier may decline to accept individuals applying for
1564 individual enrollment, other than individuals applying for coverage as set forth in Health
1565 Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]
1566 [(b) Within two calendar days of taking action under Subsection (6)(a), an individual
1567 carrier will provide written notice to the department.]
1568 [(7) (a) If a small employer carrier offers health benefit plans to small employers
1569 through a network plan, the small employer carrier may:]

1570 [~~(i) limit the employers that may apply for the coverage to those employers with~~
1571 ~~eligible employees who live, reside, or work in the service area for the network plan; and~~]
1572 [~~(ii) within the service area of the network plan, deny coverage to an employer if the~~
1573 ~~small employer carrier has demonstrated to the commissioner that the small employer carrier:~~]
1574 [~~(A) will not have the capacity to deliver services adequately to enrollees of any~~
1575 ~~additional groups because of the small employer carrier's obligations to existing group contract~~
1576 ~~holders and enrollees; and~~]
1577 [~~(B) applies this section uniformly to all employers without regard to:~~]
1578 [~~(I) the claims experience of an employer, an employer's employee, or a dependent of~~
1579 ~~an employee; or~~]
1580 [~~(II) any health status-related factor relating to an employee or dependent of an~~
1581 ~~employee~~].
1582 [~~(b) (i) A small employer carrier that denies a health benefit product to an employer in~~
1583 ~~any service area in accordance with this section may not offer coverage in the small employer~~
1584 ~~market within the service area to any employer for a period of 180 days after the date the~~
1585 ~~coverage is denied.~~]
1586 [~~(ii) This Subsection (7)(b) does not:~~]
1587 [~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~]
1588 [~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~
1589 ~~force.~~]
1590 [~~(c) Coverage offered within a service area after the 180-day period specified in~~
1591 ~~Subsection (7)(b) is subject to the requirements of this section.~~]
1592 Section 22. Section **31A-30-117** is amended to read:
1593 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**
1594 (1) (a) After complying with the reporting requirements of Section 63M-1-2505.5, the
1595 commissioner may adopt administrative rules that change the rating and underwriting
1596 requirements of this chapter as necessary to transition the insurance market to meet federal
1597 qualified health plan standards and rating practices under PPACA.

1598 (b) Administrative rules adopted by the commissioner under this section may include:
1599 (i) the regulation of health benefit plans as described in Subsections 31A-2-212(5)(a)
1600 and (b); and
1601 (ii) disclosure of records and information required by PPACA and state law.
1602 (c) (i) The commissioner shall establish by administrative rule one statewide open
1603 enrollment period that applies to the individual insurance market that is not on the PPACA
1604 certified individual exchange.
1605 (ii) The statewide open enrollment period:
1606 (A) may be shorter, but no longer than the open enrollment period established for the
1607 individual insurance market offered in the PPACA certified exchange; and
1608 (B) may not be extended beyond the dates of the open enrollment period established
1609 for the individual insurance market offered in the PPACA certified exchange.
1610 (2) A carrier that offers health benefit plans in the individual market that is not part of
1611 the individual PPACA certified exchange:
1612 (a) shall open enrollment:
1613 (i) during the statewide open enrollment period established in Subsection (1)(c); and
1614 (ii) at other times, for qualifying events, as determined by administrative rule adopted
1615 by the commissioner; and
1616 (b) may open enrollment at any time.
1617 [~~(3) (a) The commissioner shall identify a new mandated benefit that is in excess of the~~
1618 ~~essential health benefits required by PPACA.~~]
1619 [~~(b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to~~
1620 ~~defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c)~~
1621 ~~directly to the qualified health plan issuer on behalf of an individual who receives an advance~~
1622 ~~premium tax credit under PPACA.~~]
1623 [~~(c) The state shall quantify the cost attributable to each additional mandated benefit~~
1624 ~~specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost~~
1625 ~~associated with the mandated benefit, which shall be:~~]

1626 [~~(i) calculated in accordance with generally accepted actuarial principles and~~
1627 ~~methodologies;~~]
1628 [~~(ii) conducted by a member of the American Academy of Actuaries; and~~]
1629 [~~(iii) reported to the commissioner and to the individual exchange operating in the~~
1630 ~~state.~~]
1631 [~~(d) The commissioner may require a proponent of a new mandated benefit under~~
1632 ~~Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance~~
1633 ~~with Subsection (3)(c). The commissioner may use the cost information provided under this~~
1634 ~~Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under~~
1635 ~~Subsection (3)(b).~~]
1636 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,
1637 or federal regulation, the commissioner shall allow a health insurer to choose to continue
1638 coverage and individuals and small employers to choose to re-enroll in coverage in
1639 nongrandfathered health coverage that is not in compliance with market reforms required by
1640 PPACA.
1641 Section 23. Section **31A-30-118** is enacted to read:
1642 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**
1643 **mandates -- Cost of additional benefits.**
1644 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the
1645 essential health benefits required by PPACA.
1646 (b) The state shall quantify the cost attributable to each additional mandated benefit
1647 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost
1648 associated with the mandated benefit, which shall be:
1649 (i) calculated in accordance with generally accepted actuarial principles and
1650 methodologies;
1651 (ii) conducted by a member of the American Academy of Actuaries; and
1652 (iii) reported to the commissioner and to the individual exchange operating in the state.
1653 (c) The commissioner may require a proponent of a new mandated benefit under

1654 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance
1655 with Subsection (1)(b). The commissioner may use the cost information provided under this
1656 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).
1657 (2) If the state is required to defray the cost of additional required benefits under the
1658 provisions of 45 C.F.R. 155.170:
1659 (a) the state shall make the required payments:
1660 (i) in accordance with Subsection (3); and
1661 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;
1662 (b) an issuer of a qualified health plan that receives a payment under the provisions of
1663 Subsection (1) and 45 C.F.R. 155.170 shall:
1664 (i) reduce the premium charged to the individual on whose behalf the issuer will be
1665 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection
1666 (1); or
1667 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an
1668 individual on whose behalf the issuer received a payment under Subsection (1), in an amount
1669 equal to the amount of the payment under Subsection (1); and
1670 (c) a premium rebate made under this section is not a prohibited inducement under
1671 Section 31A-23a-402.5.
1672 (3) A payment required under 45 C.F.R. 155.170(c) shall:
1673 (a) unless otherwise required by PPACA, be based on a statewide average of the cost
1674 of the additional benefit for all issuers who are entitled to payment under the provisions of 45
1675 C.F.R. 155.70; and
1676 (b) be submitted to an issuer through a process established and administered by:
1677 (i) the federal marketplace exchange for the state under PPACA for individual health
1678 plans; or
1679 (ii) Avenue H small employer market exchange for qualified health plans offered on
1680 the exchange.
1681 (4) The commissioner:

1682 (a) may adopt rules as necessary to administer the provisions of this section and 45
1683 C.F.R. 155.170; and
1684 (b) may not establish or implement the process for submitting the payments to an issuer
1685 under Subsection (3)(b)(i) unless the cost of establishing and implementing the process for
1686 submitting payments is paid for by the federal exchange marketplace.
1687 Section 24. Section **31A-30-301** is enacted to read:
1688 **Part 3. Individual and Small Employer Risk Adjustment Act**
1689 **31A-30-301. Title.**
1690 This part is known as the "Individual and Small Employer Risk Adjustment Act."
1691 Section 25. Section **31A-30-302** is enacted to read:
1692 **31A-30-302. Creation of state risk adjustment program.**
1693 (1) The commissioner shall convene a group of stakeholders and actuaries to assist the
1694 commissioner with the evaluation or the risk adjustment options described in Subsection (2). If
1695 the commissioner determines that a state-based risk adjustment program is in the best interest
1696 of the state, the commissioner shall establish an individual and small employer market risk
1697 adjustment program in accordance with 42 U.S.C. 18063 and this section.
1698 (2) The risk adjustment program adopted by the commissioner may include one of the
1699 following models:
1700 (a) continue the United States Department of Health and Human Services
1701 administration of the federal model for risk adjustment for the individual and small employer
1702 market in the state;
1703 (b) have the state administer the federal model for risk adjustment for the individual
1704 and small employer market in the state;
1705 (c) establish and operate a state-based risk adjustment program for the individual and
1706 small employer market in the state; or
1707 (d) another risk adjustment model developed by the commissioner under Subsection
1708 (1).
1709 (3) Before adopting one of the models described in Subsection (2), the commissioner:

1710 (a) may enter into contracts to carry out the services needed to evaluate and establish
1711 one of the risk adjustment options described in Subsection (2); and
1712 (b) shall, prior to October 30, 2014, comply with the reporting requirements of Section
1713 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options
1714 described in Subsection (2).
1715 (4) The commissioner may:
1716 (a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah
1717 Administrative Rulemaking Act, that require an insurer that is subject to the state-based risk
1718 adjustment program to submit data to the all payers claims database created under Section
1719 26-33a-106.1; and
1720 (b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act,
1721 to cover the ongoing administrative cost of running the state-based risk adjustment program.
1722 Section 26. Section **31A-30-303** is enacted to read:
1723 **31A-30-303. Enterprise fund.**
1724 (1) There is created an enterprise fund known as the Individual and Small Employer
1725 Risk Adjustment Enterprise Fund.
1726 (2) The following funds shall be credited to the fund:
1727 (a) appropriations from the General Fund;
1728 (b) fees established by the commissioner under Section 31A-30-302;
1729 (c) risk adjustment payments received from insurers participating in the risk adjustment
1730 program; and
1731 (d) all interest and dividends earned on the fund's assets.
1732 (3) All money received by the fund shall be deposited in compliance with Section
1733 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51,
1734 Chapter 7, State Money Management Act.
1735 (4) The fund shall comply with the accounting policies, procedures, and reporting
1736 requirements established by the Division of Finance.
1737 (5) The fund shall comply with Title 63A, Utah Administrative Services Code.

1738 (6) The fund shall be used to implement and operate the risk adjustment program
1739 created by this part.
1740 Section 27. Section **63A-5-205** is amended to read:
1741 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**
1742 **coverage.**
1743 (1) As used in this section:
1744 (a) "Capital developments" has the same meaning as provided in Section 63A-5-104.
1745 (b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.
1746 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section
1747 34A-2-104 who:
1748 (i) works at least 30 hours per calendar week; and
1749 (ii) meets employer eligibility waiting requirements for health care insurance which
1750 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
1751 hire.
1752 (d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
1753 (e) "Qualified health insurance coverage" is as defined in Section 26-40-115.
1754 (f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
1755 (2) In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the director
1756 may:
1757 (a) subject to Subsection (3), enter into contracts for any work or professional services
1758 which the division or the State Building Board may do or have done; and
1759 (b) as a condition of any contract for architectural or engineering services, prohibit the
1760 architect or engineer from retaining a sales or agent engineer for the necessary design work.
1761 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design
1762 or construction contracts entered into by the division or the State Building Board on or after
1763 July 1, 2009, and:
1764 (i) applies to a prime contractor if the prime contract is in the amount of $1,500,000 or
1765 greater; and

1766 (ii) applies to a subcontractor if the subcontract is in the amount of $750,000 or greater.
1767 (b) This Subsection (3) does not apply:
1768 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;
1769 (ii) if the contract is a sole source contract;
1770 (iii) if the contract is an emergency procurement; or
1771 (iv) to a change order as defined in Section 63G-6a-103, or a modification to a
1772 contract, when the contract does not meet the threshold required by Subsection (3)(a).
1773 (c) A person who intentionally uses change orders or contract modifications to
1774 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.
1775 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that
1776 the contractor has and will maintain an offer of qualified health insurance coverage for the
1777 contractor's employees and the employees' dependents.
1778 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor
1779 shall demonstrate to the director that the subcontractor has and will maintain an offer of
1780 qualified health insurance coverage for the subcontractor's employees and the employees'
1781 dependents.
1782 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)
1783 during the duration of the contract is subject to penalties in accordance with administrative
1784 rules adopted by the division under Subsection (3)(f).
1785 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1786 requirements of Subsection (3)(d)(ii).
1787 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)
1788 during the duration of the contract is subject to penalties in accordance with administrative
1789 rules adopted by the division under Subsection (3)(f).
1790 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1791 requirements of Subsection (3)(d)(i).
1792 (f) The division shall adopt administrative rules:
1793 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1794 (ii) in coordination with:
1795 (A) the Department of Environmental Quality in accordance with Section 19-1-206;
1796 (B) the Department of Natural Resources in accordance with Section 79-2-404;
1797 (C) a public transit district in accordance with Section 17B-2a-818.5;
1798 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;
1799 (E) the Department of Transportation in accordance with Section 72-6-107.5; and
1800 (F) the Legislature's Administrative Rules Review Committee; and
1801 (iii) which establish:
1802 (A) the requirements and procedures a contractor must follow to demonstrate to the
1803 director compliance with this Subsection (3) which shall include:
1804 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)
1805 or (ii) more than twice in any 12-month period; and
1806 (II) that the actuarially equivalent determination required for the qualified health
1807 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
1808 department or division with a written statement of actuarial equivalency from either:
1809 (Aa) the Utah Insurance Department;
1810 (Bb) an actuary selected by the contractor or the contractor's insurer; or
1811 (Cc) an underwriter who is responsible for developing the employer group's premium
1812 rates;
1813 (B) the penalties that may be imposed if a contractor or subcontractor intentionally
1814 violates the provisions of this Subsection (3), which may include:
1815 (I) a three-month suspension of the contractor or subcontractor from entering into
1816 future contracts with the state upon the first violation;
1817 (II) a six-month suspension of the contractor or subcontractor from entering into future
1818 contracts with the state upon the second violation;
1819 (III) an action for debarment of the contractor or subcontractor in accordance with
1820 Section 63G-6a-904 upon the third or subsequent violation; and
1821 (IV) monetary penalties which may not exceed 50% of the amount necessary to

1822 purchase qualified health insurance coverage for an employee and the dependents of an
1823 employee of the contractor or subcontractor who was not offered qualified health insurance
1824 coverage during the duration of the contract; and
1825 (C) a website on which the department shall post the benchmark for the qualified
1826 health insurance coverage identified in Subsection (1)(e).
1827 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or
1828 subcontractor who intentionally violates the provisions of this section shall be liable to the
1829 employee for health care costs that would have been covered by qualified health insurance
1830 coverage.
1831 (ii) An employer has an affirmative defense to a cause of action under Subsection
1832 (3)(g)(i) if:
1833 (A) the employer relied in good faith on a written statement of actuarial equivalency
1834 provided by:
1835 (I) an actuary; or
1836 (II) an underwriter who is responsible for developing the employer group's premium
1837 rates; or
1838 (B) the department determines that compliance with this section is not required under
1839 the provisions of Subsection (3)(b).
1840 (iii) An employee has a private right of action only against the employee's employer to
1841 enforce the provisions of this Subsection (3)(g).
1842 (h) Any penalties imposed and collected under this section shall be deposited into the
1843 Medicaid Restricted Account created by Section 26-18-402.
1844 (i) The failure of a contractor or subcontractor to provide qualified health insurance
1845 coverage as required by this section:
1846 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,
1847 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
1848 Procurement Code; and
1849 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or

1850 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
1851 or construction.
1852 (4) The judgment of the director as to the responsibility and qualifications of a bidder
1853 is conclusive, except in case of fraud or bad faith.
1854 (5) The division shall make all payments to the contractor for completed work in
1855 accordance with the contract and pay the interest specified in the contract on any payments that
1856 are late.
1857 (6) If any payment on a contract with a private contractor to do work for the division or
1858 the State Building Board is retained or withheld, it shall be retained or withheld and released as
1859 provided in Section 13-8-5.
1860 Section 28. Section **63C-9-403** is amended to read:
1861 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**
1862 (1) For purposes of this section:
1863 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
1864 34A-2-104 who:
1865 (i) works at least 30 hours per calendar week; and
1866 (ii) meets employer eligibility waiting requirements for health care insurance which
1867 may not exceed the first of the calendar month following [~~90~~] 60 days from the date of hire.
1868 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
1869 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.
1870 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
1871 (2) (a) Except as provided in Subsection (3), this section applies to a design or
1872 construction contract entered into by the board or on behalf of the board on or after July 1,
1873 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).
1874 (b) (i) A prime contractor is subject to this section if the prime contract is in the
1875 amount of $1,500,000 or greater.
1876 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
1877 $750,000 or greater.

1878 (3) This section does not apply if:
1879 (a) the application of this section jeopardizes the receipt of federal funds;
1880 (b) the contract is a sole source contract; or
1881 (c) the contract is an emergency procurement.
1882 (4) (a) This section does not apply to a change order as defined in Section 63G-6a-103,
1883 or a modification to a contract, when the contract does not meet the initial threshold required
1884 by Subsection (2).
1885 (b) A person who intentionally uses change orders or contract modifications to
1886 circumvent the requirements of Subsection (2) is guilty of an infraction.
1887 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
1888 director that the contractor has and will maintain an offer of qualified health insurance
1889 coverage for the contractor's employees and the employees' dependents during the duration of
1890 the contract.
1891 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
1892 shall demonstrate to the executive director that the subcontractor has and will maintain an offer
1893 of qualified health insurance coverage for the subcontractor's employees and the employees'
1894 dependents during the duration of the contract.
1895 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
1896 the duration of the contract is subject to penalties in accordance with administrative rules
1897 adopted by the division under Subsection (6).
1898 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1899 requirements of Subsection (5)(b).
1900 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
1901 the duration of the contract is subject to penalties in accordance with administrative rules
1902 adopted by the department under Subsection (6).
1903 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1904 requirements of Subsection (5)(a).
1905 (6) The department shall adopt administrative rules:

1906 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
1907 (b) in coordination with:
1908 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
1909 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
1910 (iii) the State Building Board in accordance with Section 63A-5-205;
1911 (iv) a public transit district in accordance with Section 17B-2a-818.5;
1912 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
1913 (vi) the Legislature's Administrative Rules Review Committee; and
1914 (c) which establish:
1915 (i) the requirements and procedures a contractor must follow to demonstrate to the
1916 executive director compliance with this section which shall include:
1917 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
1918 (b) more than twice in any 12-month period; and
1919 (B) that the actuarially equivalent determination required for the qualified health
1920 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
1921 department or division with a written statement of actuarial equivalency from either:
1922 (I) the Utah Insurance Department;
1923 (II) an actuary selected by the contractor or the contractor's insurer; or
1924 (III) an underwriter who is responsible for developing the employer group's premium
1925 rates;
1926 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
1927 violates the provisions of this section, which may include:
1928 (A) a three-month suspension of the contractor or subcontractor from entering into
1929 future contracts with the state upon the first violation;
1930 (B) a six-month suspension of the contractor or subcontractor from entering into future
1931 contracts with the state upon the second violation;
1932 (C) an action for debarment of the contractor or subcontractor in accordance with
1933 Section 63G-6a-904 upon the third or subsequent violation; and

1934 (D) monetary penalties which may not exceed 50% of the amount necessary to
1935 purchase qualified health insurance coverage for employees and dependents of employees of
1936 the contractor or subcontractor who were not offered qualified health insurance coverage
1937 during the duration of the contract; and
1938 (iii) a website on which the department shall post the benchmark for the qualified
1939 health insurance coverage identified in Subsection (1)(c).
1940 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
1941 subcontractor who intentionally violates the provisions of this section shall be liable to the
1942 employee for health care costs that would have been covered by qualified health insurance
1943 coverage.
1944 (ii) An employer has an affirmative defense to a cause of action under Subsection
1945 (7)(a)(i) if:
1946 (A) the employer relied in good faith on a written statement of actuarial equivalency
1947 provided by:
1948 (I) an actuary; or
1949 (II) an underwriter who is responsible for developing the employer group's premium
1950 rates; or
1951 (B) the department determines that compliance with this section is not required under
1952 the provisions of Subsection (3) or (4).
1953 (b) An employee has a private right of action only against the employee's employer to
1954 enforce the provisions of this Subsection (7).
1955 (8) Any penalties imposed and collected under this section shall be deposited into the
1956 Medicaid Restricted Account created in Section 26-18-402.
1957 (9) The failure of a contractor or subcontractor to provide qualified health insurance
1958 coverage as required by this section:
1959 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
1960 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
1961 Procurement Code; and

1962 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
1963 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
1964 or construction.

1965 Section 29. Section **63I-1-231 (Effective 07/01/14)** is amended to read:

1966 **63I-1-231 (Effective 07/01/14). Repeal dates, Title 31A.**

1967 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.
1968 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2023.
1969 (3) Section 31A-22-619.6, Coordination of benefits with workers' compensation
1970 claim--Health insurer's duty to pay, is repealed on July 1, 2018.
1971 (4) Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is repealed July
1972 1, 2015.

1973 Section 30. Section **63M-1-2504** is amended to read:

1974 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**

1975 (1) There is created within the Governor's Office of Economic Development the Office
1976 of Consumer Health Services.
1977 (2) The office shall:
1978 (a) in cooperation with the Insurance Department, the Department of Health, and the
1979 Department of Workforce Services, and in accordance with the electronic standards developed
1980 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:
1981 (i) provides information to consumers about private and public health programs for
1982 which the consumer may qualify;
1983 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
1984 on the Health Insurance Exchange; and
1985 (iii) includes information and a link to enrollment in premium assistance programs and
1986 other government assistance programs;
1987 (b) contract with one or more private vendors for:
1988 (i) administration of the enrollment process on the Health Insurance Exchange,
1989 including establishing a mechanism for consumers to compare health benefit plan features on

1990 the exchange and filter the plans based on consumer preferences;
1991 (ii) the collection of health insurance premium payments made for a single policy by
1992 multiple payers, including the policyholder, one or more employers of one or more individuals
1993 covered by the policy, government programs, and others; and
1994 (iii) establishing a call center in accordance with Subsection [(3)] (4);
1995 (c) assist employers with a free or low cost method for establishing mechanisms for the
1996 purchase of health insurance by employees using pre-tax dollars;
1997 (d) establish a list on the Health Insurance Exchange of insurance producers who, in
1998 accordance with Section 31A-30-209, are appointed producers for the Health Insurance
1999 Exchange; [and]
2000 (e) submit, before November 1, an annual written report to the Business and Labor
2001 Interim Committee and the Health System Reform Task Force regarding the operations of the
2002 Health Insurance Exchange required by this chapter[.]; and
2003 (f) in accordance with Subsection (3), provide a form to a small employer that certifies:
2004 (i) that the small employer offered a qualified health plan to the small employer's
2005 employees; and
2006 (ii) the period of time within the taxable year in which the small employer maintained
2007 the qualified health plan coverage.
2008 (3) The form required by Subsection (2)(f) shall be provided to a small employer if:
2009 (a) the small employer selected a qualified health plan on the small employer health
2010 exchange created by this section; or
2011 (b) (i) the small employer selected a health plan in the small employer market that is
2012 not offered through the exchange created by this section; and
2013 (ii) the issuer of the health plan selected by the small employer submits to the office, in
2014 a form and manner required by the office:
2015 (A) an affidavit from a member of the American Academy of Actuaries stating that
2016 based on generally accepted actuarial principles and methodologies the issuer's health plan
2017 meets the benefit and actuarial requirements for a qualified health plan under PPACA as

2018 defined in Section 31A-1-301; and
2019 (B) an affidavit from the issuer that includes the dates of coverage for the small
2020 employer during the taxable year.
2021 [(3)] (4) A call center established by the office:
2022 (a) shall provide unbiased answers to questions concerning exchange operations, and
2023 plan information, to the extent the plan information is posted on the exchange by the insurer;
2024 and
2025 (b) may not:
2026 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;
2027 (ii) receive producer compensation through the Health Insurance Exchange; and
2028 (iii) be designated as the default producer for an employer group that enters the Health
2029 Insurance Exchange without a producer.
2030 [(4)] (5) The office:
2031 (a) may not:
2032 (i) regulate health insurers, health insurance plans, health insurance producers, or
2033 health insurance premiums charged in the exchange;
2034 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or
2035 (iii) act as an appeals entity for resolving disputes between a health insurer and an
2036 insured;
2037 (b) may establish and collect a fee for the cost of the exchange transaction in
2038 accordance with Section 63J-1-504 for:
2039 (i) processing an application for a health benefit plan;
2040 (ii) accepting, processing, and submitting multiple premium payment sources;
2041 (iii) providing a mechanism for consumers to filter and compare health benefit plans in
2042 the exchange based on consumer preferences; and
2043 (iv) funding the call center; and
2044 (c) shall separately itemize the fee established under Subsection [(4)] (5)(b) as part of
2045 the cost displayed for the employer selecting coverage on the exchange.

2046 Section 31. Section **72-6-107.5** is amended to read:

2047 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**
2048 **insurance coverage.**

2049 (1) For purposes of this section:

2050 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2051 34A-2-104 who:

2052 (i) works at least 30 hours per calendar week; and

2053 (ii) meets employer eligibility waiting requirements for health care insurance which
2054 may not exceed the first day of the calendar month following [90] 60 days from the date of
2055 hire.

2056 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2057 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

2058 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2059 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered
2060 into by the department on or after July 1, 2009, for construction or design of highways and to a
2061 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

2062 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2063 amount of $1,500,000 or greater.

2064 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2065 $750,000 or greater.

2066 (3) This section does not apply if:

2067 (a) the application of this section jeopardizes the receipt of federal funds;

2068 (b) the contract is a sole source contract; or

2069 (c) the contract is an emergency procurement.

2070 (4) (a) This section does not apply to a change order as defined in Section 63G-6a-103,
2071 or a modification to a contract, when the contract does not meet the initial threshold required
2072 by Subsection (2).

2073 (b) A person who intentionally uses change orders or contract modifications to

2074 circumvent the requirements of Subsection (2) is guilty of an infraction.

2075 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
2076 the contractor has and will maintain an offer of qualified health insurance coverage for the
2077 contractor's employees and the employees' dependents during the duration of the contract.

2078 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
2079 demonstrate to the department that the subcontractor has and will maintain an offer of qualified
2080 health insurance coverage for the subcontractor's employees and the employees' dependents
2081 during the duration of the contract.

2082 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2083 the duration of the contract is subject to penalties in accordance with administrative rules
2084 adopted by the department under Subsection (6).

2085 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2086 requirements of Subsection (5)(b).

2087 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2088 the duration of the contract is subject to penalties in accordance with administrative rules
2089 adopted by the department under Subsection (6).

2090 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2091 requirements of Subsection (5)(a).

2092 (6) The department shall adopt administrative rules:

2093 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2094 (b) in coordination with:

2095 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2096 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

2097 (iii) the State Building Board in accordance with Section 63A-5-205;

2098 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

2099 (v) a public transit district in accordance with Section 17B-2a-818.5; and

2100 (vi) the Legislature's Administrative Rules Review Committee; and

2101 (c) which establish:

2102 (i) the requirements and procedures a contractor must follow to demonstrate to the
2103 department compliance with this section which shall include:
2104 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2105 (b) more than twice in any 12-month period; and
2106 (B) that the actuarially equivalent determination required for qualified health insurance
2107 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2108 division with a written statement of actuarial equivalency from either:
2109 (I) the Utah Insurance Department;
2110 (II) an actuary selected by the contractor or the contractor's insurer; or
2111 (III) an underwriter who is responsible for developing the employer group's premium
2112 rates;
2113 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2114 violates the provisions of this section, which may include:
2115 (A) a three-month suspension of the contractor or subcontractor from entering into
2116 future contracts with the state upon the first violation;
2117 (B) a six-month suspension of the contractor or subcontractor from entering into future
2118 contracts with the state upon the second violation;
2119 (C) an action for debarment of the contractor or subcontractor in accordance with
2120 Section 63G-6a-904 upon the third or subsequent violation; and
2121 (D) monetary penalties which may not exceed 50% of the amount necessary to
2122 purchase qualified health insurance coverage for an employee and a dependent of the employee
2123 of the contractor or subcontractor who was not offered qualified health insurance coverage
2124 during the duration of the contract; and
2125 (iii) a website on which the department shall post the benchmark for the qualified
2126 health insurance coverage identified in Subsection (1)(c).
2127 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2128 subcontractor who intentionally violates the provisions of this section shall be liable to the
2129 employee for health care costs that would have been covered by qualified health insurance

2130 coverage.

2131 (ii) An employer has an affirmative defense to a cause of action under Subsection
2132 (7)(a)(i) if:

2133 (A) the employer relied in good faith on a written statement of actuarial equivalency
2134 provided by:

2135 (I) an actuary; or

2136 (II) an underwriter who is responsible for developing the employer group's premium
2137 rates; or

2138 (B) the department determines that compliance with this section is not required under
2139 the provisions of Subsection (3) or (4).

2140 (b) An employee has a private right of action only against the employee's employer to
2141 enforce the provisions of this Subsection (7).

2142 (8) Any penalties imposed and collected under this section shall be deposited into the
2143 Medicaid Restricted Account created in Section 26-18-402.

2144 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2145 coverage as required by this section:

2146 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2147 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
2148 Procurement Code; and

2149 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2150 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2151 or construction.

2152 Section 32. Section **79-2-404** is amended to read:

2153 **79-2-404. Contracting powers of department -- Health insurance coverage.**

2154 (1) For purposes of this section:

2155 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2156 34A-2-104 who:

2157 (i) works at least 30 hours per calendar week; and

2158 (ii) meets employer eligibility waiting requirements for health care insurance which
2159 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
2160 hire.
2161 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
2162 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.
2163 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
2164 (2) (a) Except as provided in Subsection (3), this section applies a design or
2165 construction contract entered into by, or delegated to, the department or a division, board, or
2166 council of the department on or after July 1, 2009, and to a prime contractor or to a
2167 subcontractor in accordance with Subsection (2)(b).
2168 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2169 amount of $1,500,000 or greater.
2170 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2171 $750,000 or greater.
2172 (3) This section does not apply to contracts entered into by the department or a
2173 division, board, or council of the department if:
2174 (a) the application of this section jeopardizes the receipt of federal funds;
2175 (b) the contract or agreement is between:
2176 (i) the department or a division, board, or council of the department; and
2177 (ii) (A) another agency of the state;
2178 (B) the federal government;
2179 (C) another state;
2180 (D) an interstate agency;
2181 (E) a political subdivision of this state; or
2182 (F) a political subdivision of another state; or
2183 (c) the contract or agreement is:
2184 (i) for the purpose of disbursing grants or loans authorized by statute;
2185 (ii) a sole source contract; or

2186 (iii) an emergency procurement.

2187 (4) (a) This section does not apply to a change order as defined in Section 63G-6a-103,
2188 or a modification to a contract, when the contract does not meet the initial threshold required
2189 by Subsection (2).

2190 (b) A person who intentionally uses change orders or contract modifications to
2191 circumvent the requirements of Subsection (2) is guilty of an infraction.

2192 (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department
2193 that the contractor has and will maintain an offer of qualified health insurance coverage for the
2194 contractor's employees and the employees' dependents during the duration of the contract.

2195 (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor
2196 shall demonstrate to the department that the subcontractor has and will maintain an offer of
2197 qualified health insurance coverage for the subcontractor's employees and the employees'
2198 dependents during the duration of the contract.

2199 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2200 the duration of the contract is subject to penalties in accordance with administrative rules
2201 adopted by the department under Subsection (6).

2202 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2203 requirements of Subsection (5)(b).

2204 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2205 the duration of the contract is subject to penalties in accordance with administrative rules
2206 adopted by the department under Subsection (6).

2207 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2208 requirements of Subsection (5)(a).

2209 (6) The department shall adopt administrative rules:

2210 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2211 (b) in coordination with:

2212 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2213 (ii) a public transit district in accordance with Section 17B-2a-818.5;

2214 (iii) the State Building Board in accordance with Section 63A-5-205;
2215 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
2216 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
2217 (vi) the Legislature's Administrative Rules Review Committee; and
2218 (c) which establish:
2219 (i) the requirements and procedures a contractor must follow to demonstrate
2220 compliance with this section to the department which shall include:
2221 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2222 (b) more than twice in any 12-month period; and
2223 (B) that the actuarially equivalent determination required for qualified health insurance
2224 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2225 division with a written statement of actuarial equivalency from either:
2226 (I) the Utah Insurance Department;
2227 (II) an actuary selected by the contractor or the contractor's insurer; or
2228 (III) an underwriter who is responsible for developing the employer group's premium
2229 rates;
2230 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2231 violates the provisions of this section, which may include:
2232 (A) a three-month suspension of the contractor or subcontractor from entering into
2233 future contracts with the state upon the first violation;
2234 (B) a six-month suspension of the contractor or subcontractor from entering into future
2235 contracts with the state upon the second violation;
2236 (C) an action for debarment of the contractor or subcontractor in accordance with
2237 Section 63G-6a-904 upon the third or subsequent violation; and
2238 (D) monetary penalties which may not exceed 50% of the amount necessary to
2239 purchase qualified health insurance coverage for an employee and a dependent of an employee
2240 of the contractor or subcontractor who was not offered qualified health insurance coverage
2241 during the duration of the contract; and

2242 (iii) a website on which the department shall post the benchmark for the qualified
2243 health insurance coverage identified in Subsection (1)(c).
2244 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2245 subcontractor who intentionally violates the provisions of this section shall be liable to the
2246 employee for health care costs that would have been covered by qualified health insurance
2247 coverage.
2248 (ii) An employer has an affirmative defense to a cause of action under Subsection
2249 (7)(a)(i) if:
2250 (A) the employer relied in good faith on a written statement of actuarial equivalency
2251 provided by:
2252 (I) an actuary; or
2253 (II) an underwriter who is responsible for developing the employer group's premium
2254 rates; or
2255 (B) the department determines that compliance with this section is not required under
2256 the provisions of Subsection (3) or (4).
2257 (b) An employee has a private right of action only against the employee's employer to
2258 enforce the provisions of this Subsection (7).
2259 (8) Any penalties imposed and collected under this section shall be deposited into the
2260 Medicaid Restricted Account created in Section 26-18-402.
2261 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2262 coverage as required by this section:
2263 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2264 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
2265 Procurement Code; and
2266 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2267 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2268 or construction.
2269 Section 33. **Effective date.**

2270 (1) Except as provided in Subsection (2), this bill takes effect May 13, 2014.
2271 (2) The amendments to Section 63I-1-231 (Effective 07/01/14) take effect on July 1,
2272 2014.

2273 Section 34. **Coordinating H.B. 141 with H.B. 24 -- Superseding technical and**
2274 **substantive amendments.**

2275 If this H.B. 141 and H.B. 24, Insurance Related Amendments, both pass and become
2276 law, it is the intent of the Legislature that the amendments to Sections 31A-23b-205 and
2277 31A-23b-206 in this bill, supersede the amendments to Sections 31A-23b-205 and
2278 31A-23b-206 in H.B. 24, when the Office of Legislative Research and General Counsel
2279 prepares the Utah Code database for publication.

2280 Section 35. **Coordinating H.B. 141 with H.B. 35 -- Superseding technical and**
2281 **substantive amendments.**

2282 If this H.B. 141 and H.B. 35, Reauthorization of Health Data Authority Act, both pass
2283 and become law, it is the intent of the Legislature that the amendments to Section 26-33a-106.1
2284 in this bill, supersede the amendments to Section 26-33a-106.1 in H.B. 35, when the Office of
2285 Legislative Research and General Counsel prepares the Utah Code database for publication.