LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: P. Owen ₵
₵ 02-14-11 12:34 PM ₵

H.B. 291

CONSOLIDATION OF INSURANCE DEPARTMENT INTO THE DEPARTMENT OF COMMERCE

2011 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Wayne A. Harper

Senate Sponsor: _____

LONG TITLE

General Description:

This bill modifies provisions related to commerce and insurance to merge the Utah Insurance Department into the Department of Commerce, including providing for a transition.

Highlighted Provisions:

This bill:

- modifies definitions;
- creates the Division of Insurance within the Department of Commerce, including:
  - providing for a transition;
  - providing for the appointment of a commissioner by the executive director;
  - addressing staff; and
  - addressing money collected under the Insurance Code; and
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides an effective date.

This bill provides revisor instructions.

Utah Code Sections Affected:

H.B. 291

AMENDS:

7-1-104, as last amended by Laws of Utah 2009, Chapter 356

7-1-1006, as last amended by Laws of Utah 2010, Chapter 65

7-5-1, as last amended by Laws of Utah 2003, Chapter 301

13-1-2, as last amended by Laws of Utah 2010, Chapter 278

17B-2a-818.5, as last amended by Laws of Utah 2010, Chapter 229

19-1-206, as last amended by Laws of Utah 2010, Chapters 218 and 229

26-1-37, as last amended by Laws of Utah 2010, Chapter 68

26-18-14, as enacted by Laws of Utah 2008, Chapter 383

26-33a-106.1, as last amended by Laws of Utah 2010, Chapter 68

26-45-104, as enacted by Laws of Utah 2002, Chapter 120

31A-1-301, as last amended by Laws of Utah 2010, Chapter 10

34A-2-103, as last amended by Laws of Utah 2008, Chapters 250, 263, and 318

34A-2-107, as last amended by Laws of Utah 2010, Chapter 286

34A-2-202, as last amended by Laws of Utah 2009, Chapter 212

35A-1-104.5, as enacted by Laws of Utah 2008, Chapter 383

35A-4-312, as last amended by Laws of Utah 2009, Chapter 349

36-12-5, as last amended by Laws of Utah 2008, Chapter 142

41-3-201, as last amended by Laws of Utah 2010, Chapter 393

49-20-405, as renumbered and amended by Laws of Utah 2002, Chapter 250

58-9-302, as last amended by Laws of Utah 2009, Chapter 183

58-9-701, as last amended by Laws of Utah 2008, Chapter 382

58-56-17, as last amended by Laws of Utah 2009, Chapter 72

59-9-105, as last amended by Laws of Utah 2002, Chapter 308

59-10-1023, as enacted by Laws of Utah 2008, Chapter 389

63A-5-205, as last amended by Laws of Utah 2010, Chapter 229

63C-6-101, as last amended by Laws of Utah 2007, Chapter 66

63C-9-403, as last amended by Laws of Utah 2010, Chapter 229

63G-2-302, as last amended by Laws of Utah 2010, Chapters 36 and 379

63J-1-201, as last amended by Laws of Utah 2010, Chapter 415

63K-1-102, as last amended by Laws of Utah 2010, Chapter 334

63M-1-2503, as enacted by Laws of Utah 2008, Chapter 383
63M-1-2504, as last amended by Laws of Utah 2010, Chapter 68
63M-1-2506, as last amended by Laws of Utah 2010, Chapter 68
67-19-6.7, as last amended by Laws of Utah 2010, Chapter 249
67-19c-101, as last amended by Laws of Utah 2006, Chapter 139
67-22-2, as last amended by Laws of Utah 2009, Chapter 369
70C-6-105, as enacted by Laws of Utah 1985, Chapter 159
70C-6-106, as enacted by Laws of Utah 1985, Chapter 159
70C-6-203, as last amended by Laws of Utah 2004, Chapter 90
72-6-107.5, as last amended by Laws of Utah 2010, Chapter 229
76-6-521, as last amended by Laws of Utah 2004, Chapter 104
76-10-915, as last amended by Laws of Utah 2010, Chapter 154
77-20-5, as last amended by Laws of Utah 1998, Chapter 293
78B-3-403, as last amended by Laws of Utah 2009, Chapter 220
78B-3-413, as last amended by Laws of Utah 2009, Chapter 146
79-2-404, as last amended by Laws of Utah 2010, Chapter 229

ENACTS:

31A-2a-101, Utah Code Annotated 1953
31A-2a-102, Utah Code Annotated 1953
31A-2a-103, Utah Code Annotated 1953
31A-2a-201, Utah Code Annotated 1953
31A-2a-202, Utah Code Annotated 1953
31A-2a-203, Utah Code Annotated 1953
31A-2a-204, Utah Code Annotated 1953

REPEALS:

31A-2-102, as last amended by Laws of Utah 2002, Chapter 176
31A-2-103, as last amended by Laws of Utah 1994, Chapter 128
31A-2-105, as last amended by Laws of Utah 1993, Chapter 305

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

Section 1. Section **7-1-104** is amended to read:

7-1-104. Exemptions from application of title.

(1) This title does not apply to:

(a) investment companies registered under the Investment Company Act of 1940, 15 U.S.C. Sec. 80a-1 et seq.;

(b) securities brokers and dealers registered pursuant to:

(i) Title 61, Chapter 1, Utah Uniform Securities Act; or

(ii) the federal Securities Exchange Act of 1934, 15 U.S.C. Sec. 78a et seq.;

(c) depository or other institutions performing transaction account services, including third party transactions, in connection with:

(i) the purchase and redemption of investment company shares; or

(ii) access to a margin or cash securities account maintained by a person identified in Subsection (1)(b); or

(d) insurance companies selling interests in an investment company or "separate account" and subject to regulation by the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance.

(2) (a) An institution, organization, or person is not exempt from this title if, within this state, it holds itself out to the public as receiving and holding deposits from residents of this state, whether evidenced by a certificate, promissory note, or otherwise.

(b) An investment company is not exempt from this title unless the investment company is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940, 15 U.S.C. Sec. 80a-1 et seq., and is advised by an investment adviser:

(i) which is registered with the United States Securities and Exchange Commission under the Investment Advisers Act of 1940, 15 U.S.C. Sec. 80b-1 et seq.; and

(ii) which advises investment companies and other accounts with a combined value of at least $50,000,000.

Section 2. Section **7-1-1006** is amended to read:

7-1-1006. Inapplicable to certain official investigations.

(1) Sections 7-1-1002 and 7-1-1003 do not apply if an examination of a record is a part of an official investigation by:

(a) local police;

(b) a sheriff;

(c) a peace officer;

(d) a city attorney;

(e) a county attorney;

(f) a district attorney;

(g) the attorney general;

(h) the Department of Public Safety;

(i) the Office of Recovery Services of the Department of Human Services;

[~~(j) the Insurance Department;~~]

[~~(k)~~] (j) the Department of Commerce;

[~~(l)~~] (k) the Benefit Payment Control Unit or the Payment Error Prevention Unit of the Department of Workforce Services;

[~~(m)~~] (l) the state auditor; or

[~~(n)~~] (m) the State Tax Commission.

(2) Except for the Office of Recovery Services, if a governmental entity listed in Subsection (1) seeks a record, the entity shall obtain the record as follows:

(a) if the record is a nonprotected record, by request in writing that:

(i) certifies that an official investigation is being conducted; and

(ii) is signed by a representative of the governmental entity that is conducting the official investigation; or

(b) if the record is a protected record, by obtaining:

(i) a subpoena authorized by statute;

(ii) other legal process:

(A) ordered by a court of competent jurisdiction; and

(B) served upon the financial institution; or

(iii) written permission from all account holders of the account referenced in the record to be examined.

(3) If the Office of Recovery Services seeks a record, the Office of Recovery Services shall obtain the record pursuant to:

(a) Subsection 62A-11-104(1)(g);

(b) Section 62A-11-304.1;

(c) Section 62A-11-304.5; or

(d) Title IV, Part D of the Social Security Act as codified in 42 U.S.C. Sec. 651 et seq.

(4) A financial institution may not give notice to an account holder or person named or referenced within the record disclosed pursuant to Subsection (2)(a).

(5) In accordance with Section 7-1-1004, the governmental entity conducting the official investigation that obtains a record from a financial institution under this section shall reimburse the financial institution for costs reasonably and directly incurred by the financial institution.

Section 3. Section **7-5-1** is amended to read:

7-5-1. Definitions -- Allowable trust companies -- Exceptions.

(1) As used in this chapter:

(a) "Business trust" means an entity engaged in a trade or business that is created by a declaration of trust that transfers property to trustees, to be held and managed by them for the benefit of persons holding certificates representing the beneficial interest in the trust estate and assets.

(b) "Trust business" means, except as provided in Subsection (1)(c), a business in which one acts in any agency or fiduciary capacity, including that of personal representative, executor, administrator, conservator, guardian, assignee, receiver, depositary, or trustee under appointment as trustee for any purpose permitted by law, including the definition of "trust" set forth in [~~Subsection~~] Section 75-1-201[~~(53)~~].

(c) "Trust business" does not include the following means of holding funds, assets, or other property:

(i) funds held in a client trust account by an attorney authorized to practice law in this state;

(ii) funds held in connection with the purchase or sale of real estate by a person authorized to act as a real estate broker in this state;

(iii) funds or other assets held in escrow by a person authorized by the department in accordance with Chapter 22, Regulation of Independent Escrow Agents, or by the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, to act as an escrow agent in this state;

(iv) funds held by a homeowners' association or similar organization to pay maintenance and other related costs for commonly owned property;

(v) funds held in connection with the collection of debts or payments on loans by a person acting solely as the agent or representative or otherwise at the sole direction of the person to which the debt or payment is owed, including funds held by an escrow agent for payment of taxes or insurance;

(vi) funds and other assets held in trust on an occasional or isolated basis by a person who does not represent that he is engaged in the trust business in Utah;

(vii) funds or other assets found by a court to be held in an implied, resulting, or constructive trust;

(viii) funds or other assets held by a court appointed conservator, guardian, receiver, trustee, or other fiduciary if:

(A) the conservator, receiver, guardian, trustee, or other fiduciary is responsible to the court in the same manner as a personal representative under Title 75, Chapter 3, Part 5, Supervised Administration, or as a receiver under Rule 66, Utah Rules of Civil Procedure;

(B) the conservator, trustee, or other fiduciary is a certified public accountant or has qualified for and received a designation as a certified financial planner, chartered financial consultant, certified financial analyst, or similar designation suitable to the court, that evidences the conservator's, trustee's, or other fiduciary's professional competence to manage financial matters;

(C) no trust company is willing or eligible to serve as conservator, guardian, trustee, or receiver after notice has been given pursuant to Section 75-1-401 to all trust companies doing business in this state, including a statement of the value of the assets to be managed. That notice need not be provided, however, if a trust company has been employed by the fiduciary to manage the assets; and

(D) in the event guardianship services are needed, the person seeking appointment as a guardian under this Subsection (1) is a specialized care professional, as that term is defined in Section 75-5-311, or a business or state agency that employs the services of one of those professionals for the purpose of caring for the incapacitated person, so long as the specialized care professional, business, or state agency does not:

(I) profit financially or otherwise from, or receive compensation for acting in that

capacity, except for the direct costs of providing guardianship or conservatorship services; or

(II) otherwise have a conflict of interest in providing those services;

(ix) funds or other assets held by a credit services organization operating in compliance with Title 13, Chapter 21, Credit Services Organizations Act;

(x) funds, securities, or other assets held in a customer account in connection with the purchase or sale of securities by a regulated securities broker, dealer, or transfer agent; or

(xi) funds, assets, and other property held in a business trust for the benefit of holders of certificates of beneficial interest if the fiduciary activities of the business trust are merely incidental to conducting business in the business trust form.

(d) "Trust company" means an institution authorized to engage in the trust business under this chapter. Only the following may be a trust company:

(i) a Utah depository institution or its wholly owned subsidiary;

(ii) an out-of-state depository institution authorized to engage in business as a depository institution in Utah or its wholly owned subsidiary;

(iii) a corporation, including a credit union service organization, owned entirely by one or more federally insured depository institutions as defined in Subsection 7-1-103(8);

(iv) a direct or indirect subsidiary of a depository institution holding company that also has a direct or indirect subsidiary authorized to engage in business as a depository institution in Utah; and

(v) any other corporation continuously and lawfully engaged in the trust business in this state since before July 1, 1981.

(2) Only a trust company may engage in the trust business in this state.

(3) The requirements of this chapter do not apply to:

(a) an institution authorized to engage in a trust business in another state that is engaged in trust activities in this state solely to fulfill its duties as a trustee of a trust created and administered in another state;

(b) a national bank, federal savings bank, federal savings and loan association, or federal credit union authorized to engage in business as a depository institution in Utah, or any wholly owned subsidiary of any of these, to the extent the institution is authorized by its primary federal regulator to engage in the trust business in this state; or

(c) a state agency that is otherwise authorized by statute to act as a conservator,

receiver, guardian, trustee, or in any other fiduciary capacity.

Section 4. Section **13-1-2** is amended to read:

13-1-2. Creation and functions of department -- Divisions created -- Fees -- Commerce Service Account.

(1) (a) There is created the Department of Commerce.

(b) The department shall execute and administer state laws regulating business activities and occupations affecting the public interest.

(2) Within the department the following divisions are created:

(a) the Division of Occupational and Professional Licensing;

(b) the Division of Real Estate;

(c) the Division of Securities;

(d) the Division of Public Utilities;

(e) the Division of Consumer Protection; [~~and~~]

(f) the Division of Corporations and Commercial Code[~~.~~]; and

(g) the Division of Insurance.

(3) (a) Unless otherwise provided by statute, the department may adopt a schedule of fees assessed for services provided by the department by following the procedures and requirements of Section 63J-1-504.

(b) The department shall submit each fee established in this manner to the Legislature for its approval as part of the department's annual appropriations request.

(c) (i) There is created a restricted account within the General Fund known as the "Commerce Service Account."

(ii) The restricted account created in Subsection (3)(c)(i) consists of fees collected by each division and by the department.

(iii) At the end of each fiscal year, the director of the Division of Finance shall transfer into the General Fund any fee collections that are greater than the legislative appropriations from the Commerce Service Account for that year.

(d) The department may not charge or collect a fee or expend money from the restricted account without approval by the Legislature.

Section 5. Section **17B-2a-818.5** is amended to read:

17B-2a-818.5. Contracting powers of public transit districts -- Health insurance

coverage.

(1) For purposes of this section:

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

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

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

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

(c) "Qualified health insurance coverage" means at the time the contract is entered into or renewed:

(i) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(A) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(Aa) the deductible is $750 per individual and $2,250 per family; and

(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a deductible that is either:

(I) the lowest deductible permitted for a federally qualified high deductible health plan; or

(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings

account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(B) an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall demonstrate to the public transit district that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the

employee's dependents during the duration of the contract.

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

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

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

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

(6) The public transit district shall adopt ordinances:

(a) in coordination with:

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

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

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

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

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

(b) which establish:

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

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

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

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

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

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

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

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

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

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

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

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

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

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

(I) actuary; or

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

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

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

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

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

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

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

Section 6. Section **19-1-206** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

(c) "Qualified health insurance coverage" means at the time the contract is entered into or renewed:

(i) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(A) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(Aa) the deductible is $750 per individual and $2,250 per family; and

(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a deductible that is either:

(I) the lowest deductible permitted for a federally qualified high deductible health plan; or

(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(B) an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.

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

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

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

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

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

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

(b) the contract or agreement is between:

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

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

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

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

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

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

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

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

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

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

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

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules

adopted by the department under Subsection (6).

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

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

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

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

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

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and the dependents of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

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

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

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

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

(I) an actuary; or

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

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

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

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

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

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or

contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 7. Section **26-1-37** is amended to read:

26-1-37. Duty to establish standards for the electronic exchange of clinical health information.

(1) For purposes of this section:

(a) "Affiliate" means an organization that directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with another organization.

(b) "Clinical health information" shall be defined by the department by administrative rule adopted in accordance with Subsection (2).

(c) "Electronic exchange":

(i) includes:

(A) the electronic transmission of clinical health data via Internet or extranet; and

(B) physically moving clinical health information from one location to another using magnetic tape, disk, or compact disc media; and

(ii) does not include exchange of information by telephone or fax.

(d) "Health care provider" means a licensing classification that is either:

(i) licensed under Title 58, Occupations and Professions, to provide health care; or

(ii) licensed under Chapter 21, Health Care Facility Licensing and Inspection Act.

(e) "Health care system" shall include:

(i) affiliated health care providers;

(ii) affiliated third party payers; and

(iii) other arrangement between organizations or providers as described by the department by administrative rule.

(f) "Qualified network" means an entity that:

(i) is a non-profit organization;

(ii) is accredited by the Electronic Healthcare Network Accreditation Commission, or another national accrediting organization recognized by the department; and

(iii) performs the electronic exchange of clinical health information among multiple health care providers not under common control, multiple third party payers not under common

control, the department, and local health departments.

(g) "Third party payer" means:

(i) all insurers offering health insurance who are subject to Section 31A-22-614.5; and

(ii) the state Medicaid program.

(2) (a) In addition to the duties listed in Section 26-1-30, the department shall, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(i) define:

(A) "clinical health information" subject to this section; and

(B) "health system arrangements between providers or organizations" as described in Subsection (1)(e)(iii); and

(ii) adopt standards for the electronic exchange of clinical health information between health care providers and third party payers that are for treatment, payment, health care operations, or public health reporting, as provided for in 45 C.F.R. Parts 160, 162, and 164, Health Insurance Reform: Security Standards.

(b) The department shall coordinate its rule making authority under the provisions of this section with the rulemaking authority of the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, under Section 31A-22-614.5. The department shall establish procedures for developing the rules adopted under this section, which ensure that the [~~Insurance Department~~] Department of Commerce is given the opportunity to comment on proposed rules.

(3) (a) Except as provided in Subsection (3)(e), a health care provider or third party payer in Utah is required to use the standards adopted by the department under the provisions of Subsection (2) if the health care provider or third party payer elects to engage in an electronic exchange of clinical health information with another health care provider or third party payer.

(b) A health care provider or third party payer may disclose information to the department or a local health department, by electronic exchange of clinical health information, as permitted by Subsection 45 C.F.R. 164.512(b).

(c) When functioning in its capacity as a health care provider or payer, the department or a local health department may disclose clinical health information by electronic exchange to another health care provider or third party payer.

(d) An electronic exchange of clinical health information by a health care provider, a third party payer, the department, or a local health department is a disclosure for treatment, payment, or health care operations if it complies with Subsection (3)(a) or (c) and is for treatment, payment, or health care operations, as those terms are defined in 45 C.F.R. Parts 160, 162, and 164.

(e) A health care provider or third party payer is not required to use the standards adopted by the department under the provisions of Subsection (2) if the health care provider or third party payer engage in the electronic exchange of clinical health information within a particular health care system.

(4) Nothing in this section shall limit the number of networks eligible to engage in the electronic data interchange of clinical health information using the standards adopted by the department under Subsection (2)(a)(ii).

(5) The department, a local health department, a health care provider, a third party payer, or a qualified network is not subject to civil liability for a disclosure of clinical health information if the disclosure is in accordance both with Subsection (3)(a) and with Subsection (3)(b), (3)(c), or (3)(d).

(6) Within a qualified network, information generated or disclosed in the electronic exchange of clinical health information is not subject to discovery, use, or receipt in evidence in any legal proceeding of any kind or character.

(7) The department shall report on the use of the standards for the electronic exchange of clinical health information to the legislative Health and Human Services Interim Committee no later than October 15 of each year. The report shall include publicly available information concerning the costs and savings for the department, third party payers, and health care providers associated with the standards for the electronic exchange of clinical health records.

Section 8. Section **26-18-14** is amended to read:

26-18-14. Strategic plan for health system reform -- Medicaid program.

The department, including the Division of Health Care Financing within the department, shall:

(1) work with the Governor's Office of Economic Development, the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance, the Department of Workforce Services, and the Legislature to develop health system

reform in accordance with the strategic plan described in Title 63M, Chapter 1, Part 25, Health System Reform Act;

(2) develop and submit amendments and waivers for the state's Medicaid plan as necessary to carry out the provisions of the Health System Reform Act;

(3) seek federal approval of an amendment to Utah's Premium Partnership for Health Insurance that would allow the state's Medicaid program to subsidize the purchase of health insurance by an individual who does not have access to employer sponsored health insurance;

(4) in coordination with the Department of Workforce Services:

(a) establish a Children's Health Insurance Program eligibility policy, consistent with federal requirements and Subsection 26-40-105(1)(d), that prohibits enrollment of a child in the program if the child's parent qualifies for assistance under Utah's Premium Partnership for Health Insurance; and

(b) involve community partners, insurance agents and producers, community based service organizations, and the education community to increase enrollment of eligible employees and individuals in Utah's Premium Partnership for Health Insurance and the Children's Health Insurance Program; and

(5) as funding permits, and in coordination with the department's adoption of standards for the electronic exchange of clinical health data, help the private sector form an alliance of employers, hospitals and other health care providers, patients, and health insurers to develop and use evidence-based health care quality measures for the purpose of improving health care decision making by health care providers, consumers, and third party payers.

Section 9. Section **26-33a-106.1** is amended to read:

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

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

(b) The advisory panel shall include:

(i) the chairman of the Utah Hospital Association;

(ii) a representative of a rural hospital as designated by the Utah Hospital Association;

(iii) a representative of the Utah Medical Association;

(iv) a physician from a small group practice as designated by the Utah Medical

Association;

(v) two representatives who are health insurers, appointed by the committee;

(vi) a representative from the Department of Health as designated by the executive director of the department;

(vii) a representative from the committee;

(viii) a consumer advocate appointed by the committee;

(ix) a member of the House of Representatives appointed by the speaker of the House; and

(x) a member of the Senate appointed by the president of the Senate.

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

(2) (a) The committee shall, as funding is available:

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

(ii) assist the demonstration projects implemented by the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, pursuant to Section 31A-22-614.6, with access to cost data, reimbursement data, care process data, and provider service data necessary for the demonstration projects' research, statistical analysis, and quality improvement activities:

(A) notwithstanding Subsection 26-33a-108(1) and Section 26-33a-109;

(B) contingent upon approval by the committee; and

(C) subject to a contract between the department and the entity providing analysis for the demonstration project;

(iii) share data regarding insurance claims with insurers participating in the defined contribution market created in Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, only to the extent necessary for:

(A) renewals of policies in the defined contribution arrangement market; and

(B) risk adjusting in the defined contribution arrangement market; and

(iv) assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting on:

(A) geographic variances in medical care and costs as demonstrated by data available to the committee; and

(B) rate and price increases by health care providers:

(I) that exceed the Consumer Price Index - Medical as provided by the United States Bureau of Labor statistics;

(II) as calculated yearly from June to June; and

(III) as demonstrated by data available to the committee.

(b) The plan adopted under this Subsection (2) shall include:

(i) the type of data that will be collected;

(ii) how the data will be evaluated;

(iii) how the data will be used;

(iv) the extent to which, and how the data will be protected; and

(v) who will have access to the data.

Section 10. Section **26-45-104** is amended to read:

26-45-104. Restrictions on health insurers.

(1) Except as provided in Subsection (2), an insurer offering health care insurance as defined in Section 31A-1-301 may not in connection with the offer or renewal of an insurance product or in the determination of premiums, coverage, renewal, cancellation, or any other underwriting decision that pertains directly to the individual or any group of which the individual is a member that purchases insurance jointly:

(a) access or otherwise take into consideration private genetic information about an asymptomatic individual;

(b) request or require an asymptomatic individual to consent to a release for the purpose of accessing private genetic information about the individual;

(c) request or require an asymptomatic individual or his blood relative to submit to a genetic test; and

(d) inquire into or otherwise take into consideration the fact that an asymptomatic individual or his blood relative has taken or refused to take a genetic test.

(2) An insurer offering health care insurance:

(a) may request information regarding the necessity of a genetic test, but not the results of the test, if a claim for payment for the test has been made against an individual's health

insurance policy;

(b) may request that portion of private genetic information that is necessary to determine the insurer's obligation to pay for health care services where:

(i) the primary basis for rendering such services to an individual is the result of a genetic test; and

(ii) a claim for payment for such services has been made against the individual's health insurance policy;

(c) may only store information obtained under this Subsection (2) in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996; and

(d) may only use or otherwise disclose the information obtained under this Subsection (2) in connection with a proceeding to determine the obligation of an insurer to pay for a genetic test or health care services, provided that, in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996, the insurer makes a reasonable effort to limit disclosure to the minimum necessary to carry out the purposes of the disclosure.

(3) (a) An insurer may, to the extent permitted by Subsection (2), seek an order compelling the disclosure of private genetic information held by an individual or third party.

(b) An order authorizing the disclosure of private genetic information pursuant to this Subsection (2) shall:

(i) limit disclosure to those parts of the record containing information essential to fulfill the objectives of the order;

(ii) limit disclosure to those persons whose need for the information is the basis for the order; and

(iii) include such other measures as may be necessary to limit disclosure for the protection of the individual.

(4) Nothing in this section may be construed as restricting the ability of an insurer to use information other than private genetic information to take into account the health status of an individual, group, or population in determining premiums or making other underwriting decisions.

(5) Nothing in this section may be construed as requiring an insurer to pay for genetic testing.

(6) Information maintained by an insurer about an individual under this section may be

redisclosed:

(a) to protect the interests of the insurer in detecting, prosecuting, or taking legal action against criminal activity, fraud, material misrepresentations, and material omissions;

(b) to enable business decisions to be made about the purchase, transfer, merger, reinsurance, or sale of all or part of the insurer's business; and

(c) to the [~~commissioner of insurance~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, upon formal request.

Section 11. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

(1) (a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from:

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

(c) "Accident and health insurance" does not include workers' compensation insurance.

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection (159).

(4) "Adult" means an individual who has attained the age of at least 18 years.

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of individuals manage the corporations.

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which an individual does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301.

(7) "Alien insurer" means an insurer domiciled outside the United States.

(8) "Amendment" means an endorsement to an insurance policy or certificate.

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more individuals if the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life.

(10) "Application" means a document:

(a) (i) completed by an applicant to provide information about the risk to be insured; and

(ii) that contains information that is used by the insurer to evaluate risk and decide whether to:

(A) insure the risk under:

(I) the coverage as originally offered; or

(II) a modification of the coverage as originally offered; or

(B) decline to insure the risk; or

(b) used by the insurer to gather information from the applicant before issuance of an annuity contract.

(11) "Articles" or "articles of incorporation" means:

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

(13) "Binder" is defined in Section 31A-21-102.

(14) "Blanket insurance policy" means a group policy covering a defined class of persons:

(a) without individual underwriting or application; and

(b) that is determined by definition with or without designating each person covered.

(15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

(16) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(17) "Business of insurance" is defined in Subsection (85).

(18) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:

(a) Section 31A-7-201;

(b) Section 31A-8-205; or

(c) Subsection 31A-9-205(2).

(19) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated.

(b) "Bylaws" includes comparable rules for a trust or other entity that is not a corporation.

(20) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

(ii) whose exclusive purpose is to insure risks of the parent organization and an affiliated company; or

(b) in the case of a group or association, an insurer:

(i) owned by the insureds; and

(ii) whose exclusive purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(21) "Casualty insurance" means liability insurance.

(22) "Certificate" means evidence of insurance given to:

(a) an insured under a group insurance policy; or

(b) a third party.

(23) "Certificate of authority" is included within the term "license."

(24) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of a benefit according to the terms of an insurance policy.

(25) "Claims-made coverage" means an insurance contract or provision limiting

coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

(26) (a) "Commissioner," [~~or~~] "commissioner of insurance," [~~means Utah's insurance commissioner.~~] or "insurance commissioner" means the executive director of the Department of Commerce appointed in accordance with Section 13-1-3:

(i) except that the executive director may delegate a power or duty of the executive director under this title to the commissioner of the division under Section 31A-2a-202;

(ii) notwithstanding that it is defined otherwise in this title; and

(iii) unless the context requires otherwise.

(b) When appropriate, the terms listed in Subsection (26)(a) apply to the equivalent supervisory official of another jurisdiction.

(27) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection (27)(a) under an agreement effective:

(A) for the life of the insured; or

(B) for a period in excess of one year.

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection (27)(a)(ii).

(28) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (28)(a)(i) through (iii).

(b) There is no presumption that an individual holding an official position with another person controls that person solely by reason of the position.

(c) A person having a contract or arrangement giving control is considered to have control despite the illegality or invalidity of the contract or arrangement.

(d) There is a rebuttable presumption of control in a person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting securities of another person.

(29) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

(30) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(31) "Controlling producer" means a producer who directly or indirectly controls an insurer.

(32) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a limited line producer;

(III) a consultant;

(IV) a managing general agent;

(V) a reinsurance intermediary;

(VI) a third party administrator; or

(VII) an adjuster; and

(B) under:

(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

(ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance Holding Companies.

(b) "Stock corporation" means a stock insurance corporation.

(c) "Mutual" or "mutual corporation" means a mutual insurance corporation.

(33) (a) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

(b) "Creditable coverage" includes coverage that is offered through a public health plan such as:

(i) the Primary Care Network Program under a Medicaid primary care network demonstration waiver obtained subject to Section 26-18-3;

(ii) the Children's Health Insurance Program under Section 26-40-106; or

(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

(34) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

(35) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

(36) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

(37) "Credit property insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that protects the property until the debt is paid.

(38) "Credit unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(39) "Creditor" means a person, including an insured, having a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) (a) "Customer service representative" means a person that provides an insurance service and insurance product information:

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer or consultant employer.

(41) "Deadline" means a final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

(42) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is considered to have taken a specific action. If the statute so provides, a condition precedent may be the commissioner's failure to take a specific action.

(43) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

(44) "Department," "insurance department," or "department of insurance" means the [~~Insurance Department.~~] Department of Commerce created in Section 13-1-2:

(a) except that the executive director may delegate a power or duty of the department under this title to the Division of Insurance;

(b) notwithstanding that it is defined otherwise in this title; and

(c) unless the context requires otherwise.

(45) "Director" means a member of the board of directors of a corporation.

(46) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

(ii) any occupation for which the individual is reasonably suited by education, training, or experience; or

(b) perform two or more of the following basic activities of daily living:

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(47) "Disability income insurance" is defined in Subsection (76).

(48) "Domestic insurer" means an insurer organized under the laws of this state.

(49) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

(c) in the case of an alien insurer, enters into the United States.

(50) (a) "Eligible employee" means:

(i) an employee who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; or

(ii) a person described in Subsection (50)(b).

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (50)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(51) "Employee" means an individual employed by an employer.

(52) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(53) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax

revenues.

(54) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

(55) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

(b) if there is a waiting period, the first day of the waiting period.

(56) (a) "Escrow" means:

(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

(57) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

(b) a person defined as an escrow agent in Section 7-22-101.

(58) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for use in interpretation of this title.

(59) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

(60) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

(61) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

(62) (a) "Filed" means that a filing is:

(i) submitted to the department as required by and in accordance with applicable statute, rule, or filing order;

(ii) received by the department within the time period provided in applicable statute, rule, or filing order; and

(iii) accompanied by the appropriate fee in accordance with:

(A) Section 31A-3-103; or

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (62)(a).

(63) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement; or

(o) an outline of coverage.

(64) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

(65) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

(66) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

(b) "Form" does not include a document specially prepared for use in an individual case.

(67) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

(68) "General lines of authority" include:

(a) the general lines of insurance in Subsection (69);

(b) title insurance under one of the following sublines of authority:

(i) search, including authority to act as a title marketing representative;

(ii) escrow, including authority to act as a title marketing representative; and

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

(69) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

(f) variable contracts, including variable life and annuity.

(70) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

(71) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of a member of the group who is selected under a procedure defined in:

(A) the policy; or

(B) an agreement that is collateral to the policy.

(b) A group insurance policy may include a member of the policyholder's family or a dependent.

(72) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

(73) (a) Except as provided in Subsection (73)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance, such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

(ii) is offered and marketed as supplemental health insurance.

(74) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

(75) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

(76) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

(77) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

(78) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

(79) "Independently procured insurance" means insurance procured under Section 31A-15-104.

(80) "Individual" means a natural person.

(81) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

(82) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as the debts and obligations mature;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(8)(c); or

(c) an insurer is determined to be hazardous under this title.

(83) (a) "Insurance" means:

(i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or

(ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:

(i) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;

(ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and

(iii) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

(84) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(85) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance by an organization that is or is required to be licensed under this title;

(b) providing a benefit to an employee in the event of a contingency not within the control of the employee, in which the employee is entitled to the benefit as a right, which benefit may be provided either:

(i) by a single employer or by multiple employer groups; or

(ii) through one or more trusts, associations, or other entities;

(c) providing an annuity:

(i) including an annuity issued in return for a gift; and

(ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of a motor club as outlined in Subsection (113);

(e) providing another person with insurance;

(f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or surety, a contract or policy of title insurance;

(g) transacting or proposing to transact any phase of title insurance, including:

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring;

(v) transacting matters subsequent to the execution of the contract and arising out of the contract, including reinsurance; and

(vi) transacting or proposing a life settlement; and

(h) doing, or proposing to do, any business in substance equivalent to Subsections (85)(a) through (g) in a manner designed to evade this title.

(86) "Insurance consultant" or "consultant" means a person who:

(a) advises another person about insurance needs and coverages;

(b) is compensated by the person advised on a basis not directly related to the insurance placed; and

(c) except as provided in Section 31A-23a-501, is not compensated directly or indirectly by an insurer or producer for advice given.

(87) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

(88) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) With regards to the selling, soliciting, or negotiating of an insurance product to an insurance customer or an insured:

(i) "producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating a product of that insurer; and

(ii) "producer for the insured" means a producer who:

(A) is compensated directly and only by an insurance customer or an insured; and

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating a product of that insurer to an insurance customer or insured.

(89) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (89)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance policy or certificate.

(90) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

(ii) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);

(iii) a motor club;

(iv) an employee welfare plan; and

(v) a person purporting or intending to do an insurance business as a principal on that person's own account.

(b) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.

(91) "Interinsurance exchange" is defined in Subsection (142).

(92) "Involuntary unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(93) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(94) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

(95) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

(a) on the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(b) through special enrollment.

(96) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

(b) "Legal expense insurance" includes an arrangement that creates a reasonable expectation of an enforceable right.

(c) "Legal expense insurance" does not include the provision of, or reimbursement for, legal services incidental to other insurance coverage.

(97) (a) "Liability insurance" means insurance against liability:

(i) for death, injury, or disability of a human being, or for damage to property, exclusive of the coverages under:

(A) Subsection (107) for medical malpractice insurance;

(B) Subsection (134) for professional liability insurance; and

(C) Subsection (168) for workers' compensation insurance;

(ii) for a medical, hospital, surgical, and funeral benefit to a person other than the insured who is injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of a human being, exclusive of the coverages under:

(A) Subsection (107) for medical malpractice insurance;

(B) Subsection (134) for professional liability insurance; and

(C) Subsection (168) for workers' compensation insurance;

(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

(iv) for loss or damage to property caused by:

(A) the breakage or leakage of a sprinkler, water pipe, or water container; or

(B) water entering through a leak or opening in a building; or

(v) for other loss or damage properly the subject of insurance not within another kind of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

(iii) making inspection of, and issuing a certificate of inspection upon, an elevator, boiler, machinery, or apparatus of any kind when done in connection with insurance on the elevator, boiler, machinery, or apparatus.

(98) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

(b) "License" includes a certificate of authority issued to an insurer.

(99) (a) "Life insurance" means:

(i) insurance on a human life; and

(ii) insurance pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

(iv) granting an additional benefit in the event of death by accident;

(v) granting an additional benefit to safeguard the policy against lapse; and

(vi) providing an optional method of settlement of proceeds.

(100) "Limited license" means a license that:

(a) is issued for a specific product of insurance; and

(b) limits an individual or agency to transact only for that product or insurance.

(101) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) another form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

(102) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

(103) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance; and

(i) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

(104) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection (103); and

(b) a customer service representative.

(105) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

(106) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

(i) in a setting other than an acute care unit of a hospital;

(ii) for not less than 12 consecutive months for a covered person on the basis of:

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

(iii) for one or more necessary or medically necessary services that are:

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

(C) (I) a nonprofit health hospital; and

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (106)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

(b) "Long-term care insurance" includes:

(i) any of the following that provide directly or supplement long-term care insurance:

(A) a group or individual annuity or rider; or

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(107) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

(108) "Member" means a person having membership rights in an insurance corporation.

(109) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

(110) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

(111) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

(112) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

(113) "Motor club" means a person:

(a) licensed under:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

(b) that promises for an advance consideration to provide for a stated period of time one or more:

(i) legal services under Subsection 31A-11-102(1)(b);

(ii) bail services under Subsection 31A-11-102(1)(c); or

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections (113)(b)(iii)(A) through (D); or

(F) other services given in Subsections 31A-11-102(1)(b) through (f).

(114) "Mutual" means a mutual insurance corporation.

(115) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

(116) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

(117) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

(b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

(c) earnings such as freight, passage money, commissions, or profits derived from transporting goods or people upon or across the oceans or inland waterways; or

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors, owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

(118) "Order" means an order of the commissioner.

(119) "Outline of coverage" means a summary that explains an accident and health insurance policy.

(120) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

(121) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

(a) has other group health care insurance coverage; or

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or

(ii) another government health benefit.

(122) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

(j) another similar entity or combination of entities acting in concert.

(123) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

(124) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

(125) "Plan year" means:

(a) the year that is designated as the plan year in:

(i) the plan document of a group health plan; or

(ii) a summary plan description of a group health plan;

(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:

(i) the year used to determine deductibles or limits;

(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or

(iii) the employer's taxable year if:

(A) the plan does not impose deductibles or limits on a yearly basis; and

(B) (I) the plan is not insured; or

(II) the insurance policy is not renewed on an annual basis; or

(c) in a case not described in Subsection (125)(a) or (b), the calendar year.

(126) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

(b) "Policy" includes a service contract issued by:

(i) a motor club under Chapter 11, Motor Clubs;

(ii) a service contract provided under Chapter 6a, Service Contracts; and

(iii) a corporation licensed under:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

(c) "Policy" does not include:

(i) a certificate under a group insurance contract; or

(ii) a document that does not purport to have legal effect.

(127) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

(128) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

(129) "Policy summary" means a synopsis describing the elements of a life insurance policy.

(130) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that day; and

(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.

(131) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

(c) (i) "Premium" does not include consideration paid to a third party administrator for the third party administrator's services.

(ii) "Premium" includes an amount paid by a third party administrator to an insurer for insurance on the risks administered by the third party administrator.

(132) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

(133) "Proceeding" includes an action or special statutory proceeding.

(134) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

(135) (a) Except as provided in Subsection (135)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

(136) "Qualified long-term care insurance contract" or "federally tax qualified

long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or

(b) the portion of a life insurance contract that provides long-term care insurance:

(i) (A) by rider; or

(B) as a part of the contract; and

(ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue Code.

(137) "Qualified United States financial institution" means an institution that:

(a) is:

(i) organized under the laws of the United States or any state; or

(ii) in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) is regulated, supervised, and examined by a United States federal or state authority having regulatory authority over a bank or trust company; and

(c) meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of a financial institution whose letters of credit will be acceptable to the commissioner as determined by:

(i) the commissioner by rule; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

(138) (a) "Rate" means:

(i) the cost of a given unit of insurance; or

(ii) for property or casualty insurance, that cost of insurance per exposure unit either expressed as:

(A) a single number; or

(B) a pure premium rate, adjusted before the application of individual risk variations based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

(b) "Rate" does not include a minimum premium.

(139) (a) Except as provided in Subsection (139)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

(i) collecting, compiling, and furnishing loss or expense statistics;

(ii) recommending, making, or filing rates or supplementary rate information; or

(iii) advising about rate questions, except as an attorney giving legal advice.

(b) "Rate service organization" does not mean:

(i) an employee of an insurer;

(ii) a single insurer or group of insurers under common control;

(iii) a joint underwriting group; or

(iv) an individual serving as an actuarial or legal consultant.

(140) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

(141) "Received by the department" means:

(a) the date delivered to and stamped received by the department, if delivered in person;

(b) the post mark date, if delivered by mail;

(c) the delivery service's post mark or pickup date, if delivered by a delivery service;

(d) the received date recorded on an item delivered, if delivered by:

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

(142) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of the persons; and

(b) exchanging insurance contracts with one another that provide insurance coverage on each other.

(143) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

(a) the insurer transferring the risk as the "ceding insurer"; and

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

(144) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

(145) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

(146) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

(b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a liability assumed under a reinsurance contract.

(147) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

(148) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in a profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections (148)(a)(i) through (xiv); or

(xvi) another interest or instrument commonly known as a security.

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

(149) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

(150) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection (150), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(b) "Self-insurance" includes:

(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and

(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or

employees for liability or risk that is related to the relationship or employment.

(c) "Self-insurance" does not include an arrangement with an independent contractor.

(151) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

(152) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

(153) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

(154) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(155) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

(156) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

(b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting shares are owned by that person either alone or with its affiliates, except for the minimum number of shares the law of the subsidiary's domicile requires to be owned by directors or others.

(157) Subject to Subsection (83)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from the failure of a principal to pay or perform the principal's obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

(158) (a) "Surplus" means the excess of assets over the sum of paid-in capital and

liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that is designated by the insurer as permanent.

(ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require that mutuals doing business in this state maintain specified minimum levels of permanent surplus.

(iii) Except for assessable mutuals, the minimum permanent surplus requirement is the same as the minimum required capital requirement that applies to stock insurers.

(c) "Excess surplus" means:

(i) for a life insurer, accident and health insurer, health organization, or property and casualty insurer as defined in Section 31A-17-601, the lesser of:

(A) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 2.5; and

(II) the sum of the insurer's or health organization's minimum capital or permanent surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

(B) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 3.0; and

(II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

(ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

(A) 1.5; and

(B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

(159) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

(i) pension plan subject to the federal Employee Retirement Income Security Act of

1974;

(ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

(iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance for which the insurer holds a license in this state; or

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt.

(160) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

(161) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

(b) another item provided by the RBC instructions, as RBC instructions is defined in Section 31A-17-601.

(162) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

(163) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

(i) not holding a valid certificate of authority to do an insurance business in this state; or

(ii) transacting business not authorized by a valid certificate.

(b) "Admitted insurer" or "authorized insurer" means an insurer:

(i) holding a valid certificate of authority to do an insurance business in this state; and

(ii) transacting business as authorized by a valid certificate.

(164) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(165) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection (135).

(166) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

(167) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

(168) "Workers' compensation insurance" means:

(a) insurance for indemnification of an employer against liability for compensation based on:

(i) a compensable accidental injury; and

(ii) occupational disease disability;

(b) employer's liability insurance incidental to workers' compensation insurance and written in connection with workers' compensation insurance; and

(c) insurance assuring to a person entitled to workers' compensation benefits the compensation provided by law.

Section 12. Section **31A-2a-101** is enacted to read:

CHAPTER 2a. DIVISION OF INSURANCE ACT

Part 1. General Provisions

31A-2a-101. Title.

This chapter is known as the "Division of Insurance Act."

Section 13. Section **31A-2a-102** is enacted to read:

31A-2a-102. Definitions.

As used in this chapter:

(1) "Commissioner" means the commissioner of the Division of Insurance appointed in accordance with Section 31A-2a-202.

(2) "Department" means the Department of Commerce created in Section 13-1-2.

(3) "Division" means the Division of Insurance created in Section 31A-2a-201.

(4) "Executive director" means the executive director of the Department of Commerce appointed under Section 13-1-3.

Section 14. Section **31A-2a-103** is enacted to read:

31A-2a-103. Transition provisions.

(1) As used in this section:

(a) "Enacting legislation" means this bill.

(b) "Previous agency" means the Utah Insurance Department that is terminated effective July 1, 2011.

(c) "Transition period" means the period:

(i) beginning July 1, 2011; and

(ii) ending the effective date of legislation terminating the transition period.

(2) (a) It is the intent of the Legislature that the enacting legislation's only substantive change is to consolidate the operations of the previous agency into the Department of Commerce.

(b) To accomplish the intent described in Subsection (2)(a), and notwithstanding the other provisions of this title:

(i) the governor may not appoint a commissioner as provided in Section 31A-2-102, repealed by the enacting legislation;

(ii) the executive director shall appoint the commissioner of the Division of Insurance in accordance with Section 31A-2a-202;

(iii) effective July 1, 2011, the department shall administer this title, in accordance with this section;

(iv) a requirement in this title for an officer or employee of the previous agency to take an oath as a condition for service does not apply to the department; and

(v) if an ambiguity arises as to how to interpret this title, as modified by this section, the executive director may provide for the implementation of this title in a manner consistent with the intent described in Subsection (2)(a).

(3) (a) The previous agency shall assist the executive director with consolidation into the department effective July 1, 2011.

(b) A previous agency shall systematically transfer the powers and duties granted to the previous agency under this title to the department effective July 1, 2011, in accordance with the executive director's plan developed in accordance with this section.

(c) Notwithstanding Section 63J-1-410, records, personnel, property, equipment, grants, unexpended and unexpired balances of appropriations, allocations and other funds used, held, employed, available or to be made available to the previous agency for the activities, powers, duties, functions, and responsibilities transferred to the department by the enacting legislation are transferred to the department at the direction of the executive director and in accordance with this section.

(4) (a) The executive director shall serve as the transition director to provide executive direction and supervision for the implementation of the transfer of the powers and duties of the previous agency to the department in accordance with this section.

(b) The executive director shall:

(i) initiate coordination with the chief executive officer of the previous agency to facilitate the transfer of programs, positions, and administrative functions; and

(ii) develop memoranda of record identifying any pending settlements, issues of compliance with applicable federal and state laws and regulations, or other obligations to be resolved related to the authority to be transferred.

(c) The executive director shall administer the enacting legislation in a manner that promotes efficient administration and shall make internal organizational changes as necessary to complete the realignment of responsibilities required by the enacting legislation.

(d) The executive director may request the assistance of the previous agency with respect to personnel, budgeting, procurement, information systems, and other management related functions, and the previous agency shall provide the requested assistance.

(5) The rules, orders, contracts, grants, and agreements relating to the functions of the department lawfully adopted before July 1, 2011, by the previous agency shall continue to be

effective until revised, amended, or rescinded.

(6) A suit, action, or other proceeding lawfully commenced by, against, or before the previous agency does not abate by reason of the enacting legislation.

(7) (a) The executive director shall study the items listed in Subsection (7)(b), and report to the Business and Labor Interim Committee by no later than its November interim committee meeting regarding the results of the study and the need, if any, for legislation.

(b) The study items to be studied by the executive director include the following:

(i) to what extent, if any, the Division of Insurance within the department needs to be restructured or consolidated;

(ii) how best to combine from the previous agency the following:

(A) human resources functions;

(B) information technology;

(C) purchasing;

(D) administrative functions;

(E) management functions; and

(F) personnel; and

(iii) whether a position of commissioner of a division should be modified to be a deputy director.

(8) (a) The Business and Labor Interim Committee may prepare legislation by no later than its November interim committee meeting for consideration in the 2012 General Session that modifies this title to reflect the consolidation enacted by the enacting legislation.

(b) In preparing the legislation required by Subsection (8)(a), the Business and Labor Interim Committee shall consult with the executive director.

Section 15. Section **31A-2a-201** is enacted to read:

Part 2. Division of Insurance Created

31A-2a-201. Division of Insurance -- Creation.

(1) There is created within the Department of Commerce the Division of Insurance.

(2) To the extent delegated to it by the executive director, the division shall administer and enforce this title.

Section 16. Section **31A-2a-202** is enacted to read:

31A-2a-202. Commissioner.

(1) To the extent delegated by the executive director, the chief administrative officer of the division is the commissioner, who shall serve as the executive and administrative head of the division.

(2) (a) The executive director shall appoint the commissioner with the concurrence of the governor.

(b) The commissioner shall be experienced in administration and possess such additional qualifications as determined by the executive director.

(c) The executive director may remove the commissioner from that position at the will of the executive director.

(d) The commissioner shall receive compensation as provided by Title 67, Chapter 19, Utah State Personnel Management Act.

Section 17. Section **31A-2a-203** is enacted to read:

31A-2a-203. Employment of staff.

The commissioner, with the approval of the executive director, may employ necessary staff, including specialists and professionals, to assist the commissioner in performing the duties, functions, and responsibilities of the division.

Section 18. Section **31A-2a-204** is enacted to read:

31A-2a-204. Money collected under this title.

Subsection 13-1-2(3) does not apply to money collected under this title.

Section 19. Section **34A-2-103** is amended to read:

34A-2-103. Employers enumerated and defined -- Regularly employed -- Statutory employers.

(1) (a) The state, and each county, city, town, and school district in the state are considered employers under this chapter and Chapter 3, Utah Occupational Disease Act.

(b) For the purposes of the exclusive remedy in this chapter and Chapter 3, Utah Occupational Disease Act prescribed in Sections 34A-2-105 and 34A-3-102, the state is considered to be a single employer and includes any office, department, agency, authority, commission, board, institution, hospital, college, university, or other instrumentality of the state.

(2) (a) Except as provided in Subsection (4), each person, including each public utility and each independent contractor, who regularly employs one or more workers or operatives in

the same business, or in or about the same establishment, under any contract of hire, express or implied, oral or written, is considered an employer under this chapter and Chapter 3, Utah Occupational Disease Act.

(b) As used in this Subsection (2):

(i) "Independent contractor" means any person engaged in the performance of any work for another who, while so engaged, is:

(A) independent of the employer in all that pertains to the execution of the work;

(B) not subject to the routine rule or control of the employer;

(C) engaged only in the performance of a definite job or piece of work; and

(D) subordinate to the employer only in effecting a result in accordance with the employer's design.

(ii) "Regularly" includes all employments in the usual course of the trade, business, profession, or occupation of the employer, whether continuous throughout the year or for only a portion of the year.

(3) (a) The client under a professional employer organization agreement regulated under Title 31A, Chapter 40, Professional Employer Organization Licensing Act:

(i) is considered the employer of a covered employee; and

(ii) subject to Section 31A-40-209, shall secure workers' compensation benefits for a covered employee by complying with Subsection 34A-2-201(1) or (2) and commission rules.

(b) The division shall promptly inform the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance, if the division has reason to believe that a professional employer organization is not in compliance with Subsection 34A-2-201(1) or (2) and commission rules.

(4) A domestic employer who does not employ one employee or more than one employee at least 40 hours per week is not considered an employer under this chapter and Chapter 3, Utah Occupational Disease Act.

(5) (a) As used in this Subsection (5):

(i) (A) "agricultural employer" means a person who employs agricultural labor as defined in Subsections 35A-4-206(1) and (2) and does not include employment as provided in Subsection 35A-4-206(3); and

(B) notwithstanding Subsection (5)(a)(i)(A), only for purposes of determining who is a

member of the employer's immediate family under Subsection (5)(a)(ii), if the agricultural employer is a corporation, partnership, or other business entity, "agricultural employer" means an officer, director, or partner of the business entity;

(ii) "employer's immediate family" means:

(A) an agricultural employer's:

(I) spouse;

(II) grandparent;

(III) parent;

(IV) sibling;

(V) child;

(VI) grandchild;

(VII) nephew; or

(VIII) niece;

(B) a spouse of any person provided in Subsection (5)(a)(ii)(A)(II) through (VIII); or

(C) an individual who is similar to those listed in Subsections (5)(a)(ii)(A) or (B) as defined by rules of the commission; and

(iii) "nonimmediate family" means a person who is not a member of the employer's immediate family.

(b) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an agricultural employer is not considered an employer of a member of the employer's immediate family.

(c) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an agricultural employer is not considered an employer of a nonimmediate family employee if:

(i) for the previous calendar year the agricultural employer's total annual payroll for all nonimmediate family employees was less than $8,000; or

(ii) (A) for the previous calendar year the agricultural employer's total annual payroll for all nonimmediate family employees was equal to or greater than $8,000 but less than $50,000; and

(B) the agricultural employer maintains insurance that covers job-related injuries of the employer's nonimmediate family employees in at least the following amounts:

(I) $300,000 liability insurance, as defined in Section 31A-1-301; and

(II) $5,000 for health care benefits similar to benefits under health care insurance as defined in Section 31A-1-301.

(d) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an agricultural employer is considered an employer of a nonimmediate family employee if:

(i) for the previous calendar year the agricultural employer's total annual payroll for all nonimmediate family employees is equal to or greater than $50,000; or

(ii) (A) for the previous year the agricultural employer's total payroll for nonimmediate family employees was equal to or exceeds $8,000 but is less than $50,000; and

(B) the agricultural employer fails to maintain the insurance required under Subsection (5)(c)(ii)(B).

(6) An employer of agricultural laborers or domestic servants who is not considered an employer under this chapter and Chapter 3, Utah Occupational Disease Act, may come under this chapter and Chapter 3, Utah Occupational Disease Act, by complying with:

(a) this chapter and Chapter 3, Utah Occupational Disease Act; and

(b) the rules of the commission.

(7) (a) (i) As used in this Subsection (7)(a), "employer" includes any of the following persons that procures work to be done by a contractor notwithstanding whether or not the person directly employs a person:

(A) a sole proprietorship;

(B) a corporation;

(C) a partnership;

(D) a limited liability company; or

(E) a person similar to one described in Subsections (7)(a)(i)(A) through (D).

(ii) If an employer procures any work to be done wholly or in part for the employer by a contractor over whose work the employer retains supervision or control, and this work is a part or process in the trade or business of the employer, the contractor, all persons employed by the contractor, all subcontractors under the contractor, and all persons employed by any of these subcontractors, are considered employees of the original employer for the purposes of this chapter and Chapter 3, Utah Occupational Disease Act.

(b) Any person who is engaged in constructing, improving, repairing, or remodelling a residence that the person owns or is in the process of acquiring as the person's personal

residence may not be considered an employee or employer solely by operation of Subsection (7)(a).

(c) A partner in a partnership or an owner of a sole proprietorship is not considered an employee under Subsection (7)(a) if the employer who procures work to be done by the partnership or sole proprietorship obtains and relies on either:

(i) a valid certification of the partnership's or sole proprietorship's compliance with Section 34A-2-201 indicating that the partnership or sole proprietorship secured the payment of workers' compensation benefits pursuant to Section 34A-2-201; or

(ii) if a partnership or sole proprietorship with no employees other than a partner of the partnership or owner of the sole proprietorship, a workers' compensation coverage waiver issued by an insurer pursuant to Section 31A-22-1011 stating that:

(A) the partnership or sole proprietorship is customarily engaged in an independently established trade, occupation, profession, or business; and

(B) the partner or owner personally waives the partner's or owner's entitlement to the benefits of this chapter and Chapter 3, Utah Occupational Disease Act, in the operation of the partnership or sole proprietorship.

(d) A director or officer of a corporation is not considered an employee under Subsection (7)(a) if the director or officer is excluded from coverage under Subsection 34A-2-104(4).

(e) A contractor or subcontractor is not an employee of the employer under Subsection (7)(a), if the employer who procures work to be done by the contractor or subcontractor obtains and relies on either:

(i) a valid certification of the contractor's or subcontractor's compliance with Section 34A-2-201; or

(ii) if a partnership, corporation, or sole proprietorship with no employees other than a partner of the partnership, officer of the corporation, or owner of the sole proprietorship, a workers' compensation coverage waiver issued by an insurer pursuant to Section 31A-22-1011 stating that:

(A) the partnership, corporation, or sole proprietorship is customarily engaged in an independently established trade, occupation, profession, or business; and

(B) the partner, corporate officer, or owner personally waives the partner's, corporate

officer's, or owner's entitlement to the benefits of this chapter and Chapter 3, Utah Occupational Disease Act, in the operation of the partnership's, corporation's, or sole proprietorship's enterprise under a contract of hire for services.

(f) (i) For purposes of this Subsection (7)(f), "eligible employer" means a person who:

(A) is an employer; and

(B) procures work to be done wholly or in part for the employer by a contractor, including:

(I) all persons employed by the contractor;

(II) all subcontractors under the contractor; and

(III) all persons employed by any of these subcontractors.

(ii) Notwithstanding the other provisions in this Subsection (7), if the conditions of Subsection (7)(f)(iii) are met, an eligible employer is considered an employer for purposes of Section 34A-2-105 of the contractor, subcontractor, and all persons employed by the contractor or subcontractor described in Subsection (7)(f)(i)(B).

(iii) Subsection (7)(f)(ii) applies if the eligible employer:

(A) under Subsection (7)(a) is liable for and pays workers' compensation benefits as an original employer under Subsection (7)(a) because the contractor or subcontractor fails to comply with Section 34A-2-201;

(B) (I) secures the payment of workers' compensation benefits for the contractor or subcontractor pursuant to Section 34A-2-201;

(II) procures work to be done that is part or process of the trade or business of the eligible employer; and

(III) does the following with regard to a written workplace accident and injury reduction program that meets the requirements of Subsection 34A-2-111(3)(d):

(Aa) adopts the workplace accident and injury reduction program;

(Bb) posts the workplace accident and injury reduction program at the work site at which the eligible employer procures work; and

(Cc) enforces the workplace accident and injury reduction program according to the terms of the workplace accident and injury reduction program; or

(C) (I) obtains and relies on:

(Aa) a valid certification described in Subsection (7)(c)(i) or (7)(e)(i);

(Bb) a workers' compensation coverage waiver described in Subsection (7)(c)(ii) or (7)(e)(ii); or

(Cc) proof that a director or officer is excluded from coverage under Subsection 34A-2-104(4);

(II) is liable under Subsection (7)(a) for the payment of workers' compensation benefits if the contractor or subcontractor fails to comply with Section 34A-2-201;

(III) procures work to be done that is part or process in the trade or business of the eligible employer; and

(IV) does the following with regard to a written workplace accident and injury reduction program that meets the requirements of Subsection 34A-2-111(3)(d):

(Aa) adopts the workplace accident and injury reduction program;

(Bb) posts the workplace accident and injury reduction program at the work site at which the eligible employer procures work; and

(Cc) enforces the workplace accident and injury reduction program according to the terms of the workplace accident and injury reduction program.

Section 20. Section **34A-2-107** is amended to read:

34A-2-107. Appointment of workers' compensation advisory council -- Composition -- Terms of members -- Duties -- Compensation.

(1) The commissioner shall appoint a workers' compensation advisory council composed of:

(a) the following voting members:

(i) five employer representatives; and

(ii) five employee representatives; and

(b) the following nonvoting members:

(i) a representative of the Workers' Compensation Fund;

(ii) a representative of a private insurance carrier;

(iii) a representative of health care providers;

(iv) the [~~Utah insurance commissioner or the insurance commissioner's~~] executive director of the Department of Commerce, or the executive director's designee; and

(v) the commissioner or the commissioner's designee.

(2) Employers and employees shall consider nominating members of groups who

historically may have been excluded from the council, such as women, minorities, and individuals with disabilities.

(3) (a) Except as required by Subsection (3)(b), as terms of current council members expire, the commissioner shall appoint each new member or reappointed member to a two-year term beginning July 1 and ending June 30.

(b) Notwithstanding the requirements of Subsection (3)(a), the commissioner shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of council members are staggered so that approximately half of the council is appointed every two years.

(4) (a) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(b) The commissioner shall terminate the term of a council member who ceases to be representative as designated by the member's original appointment.

(5) (a) The council shall confer at least quarterly for the purpose of advising the commission, the division, and the Legislature on:

(i) the Utah workers' compensation and occupational disease laws;

(ii) the administration of the laws described in Subsection (5)(a)(i);

(iii) rules related to the laws described in Subsection (5)(a)(i); and

(iv) advising the Legislature in accordance with Subsection (5)(b).

(b) (i) The council and the commission shall jointly study during 2009 the premium assessment under Section 59-9-101 on an admitted insurer writing workers' compensation insurance in this state and on a self-insured employer under Section 34A-2-202 as to:

(A) whether or not the premium assessment should be changed; or

(B) whether or not changes should be made to how the premium assessment is used.

(ii) The council and commission shall jointly report the results of the study described in this Subsection (5)(b) to the Business and Labor Interim Committee by no later than the 2009 November interim meeting.

(6) Regarding workers' compensation, rehabilitation, and reemployment of employees who are disabled because of an industrial injury or occupational disease the council shall:

(a) offer advice on issues requested by:

(i) the commission;

(ii) the division; and

(iii) the Legislature; and

(b) make recommendations to:

(i) the commission; and

(ii) the division.

(7) The commissioner or the commissioner's designee shall serve as the chair of the council and call the necessary meetings.

(8) The commission shall provide staff support to the council.

(9) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Section 21. Section **34A-2-202** is amended to read:

34A-2-202. Assessment on self-insured employers including the state, counties, cities, towns, or school districts paying compensation direct.

(1) (a) (i) A self-insured employer, including a county, city, town, or school district, shall pay annually, on or before March 31, an assessment in accordance with this section and rules made by the commission under this section.

(ii) For purposes of this section, "self-insured employer" is as defined in Section 34A-2-201.5, except it includes the state if the state self-insures under Section 34A-2-203.

(b) The assessment required by Subsection (1)(a) is:

(i) to be collected by the State Tax Commission;

(ii) paid by the State Tax Commission into the state treasury as provided in Subsection 59-9-101(2); and

(iii) subject to the offset provided in Section 34A-2-202.5.

(c) The assessment under Subsection (1)(a) shall be based on a total calculated premium multiplied by the premium assessment rate established pursuant to Subsection 59-9-101(2).

(d) The total calculated premium, for purposes of calculating the assessment under

Subsection (1)(a), shall be calculated by:

(i) multiplying the total of the standard premium for each class code calculated in Subsection (1)(e) by the self-insured employer's experience modification factor; and

(ii) multiplying the total under Subsection (1)(d)(i) by a safety factor determined under Subsection (1)(g).

(e) A standard premium shall be calculated by:

(i) multiplying the prospective loss cost for the year being considered, as filed with the [~~insurance department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, pursuant to Section 31A-19a-406, for each applicable class code by 1.10 to determine the manual rate for each class code; and

(ii) multiplying the manual rate for each class code under Subsection (1)(e)(i) by each $100 of the self-insured employer's covered payroll for each class code.

(f) (i) Each self-insured employer paying compensation direct shall annually obtain the experience modification factor required in Subsection (1)(d)(i) by using:

(A) the rate service organization designated by the [~~insurance commissioner~~] executive director of the Department of Commerce, or the executive director's designee, in Section 31A-19a-404; or

(B) for a self-insured employer that is a public agency insurance mutual, an actuary approved by the commission.

(ii) If a self-insured employer's experience modification factor under Subsection (1)(f)(i) is less than 0.50, the self-insured employer shall use an experience modification factor of 0.50 in determining the total calculated premium.

(g) To provide incentive for improved safety, the safety factor required in Subsection (1)(d)(ii) shall be determined based on the self-insured employer's experience modification factor as follows:

EXPERIENCE MODIFICATION FACTOR	SAFETY FACTOR
Less than or equal to 0.90	0.56
Greater than 0.90 but less than or equal to 1.00	0.78
Greater than 1.00 but less than or equal to 1.10	1.00

Greater than 1.10 but less than or equal to 1.20	1.22
Greater than 1.20	1.44

(h) (i) A premium or premium assessment modification other than a premium or premium assessment modification under this section may not be allowed.

(ii) If a self-insured employer paying compensation direct fails to obtain an experience modification factor as required in Subsection (1)(f)(i) within the reasonable time period established by rule by the State Tax Commission, the State Tax Commission shall use an experience modification factor of 2.00 and a safety factor of 2.00 to calculate the total calculated premium for purposes of determining the assessment.

(iii) Prior to calculating the total calculated premium under Subsection (1)(h)(ii), the State Tax Commission shall provide the self-insured employer with written notice that failure to obtain an experience modification factor within a reasonable time period, as established by rule by the State Tax Commission:

(A) shall result in the State Tax Commission using an experience modification factor of 2.00 and a safety factor of 2.00 in calculating the total calculated premium for purposes of determining the assessment; and

(B) may result in the division revoking the self-insured employer's right to pay compensation direct.

(i) The division may immediately revoke a self-insured employer’s certificate issued under Sections 34A-2-201 and 34A-2-201.5 that permits the self-insured employer to pay compensation direct if the State Tax Commission assigns an experience modification factor and a safety factor under Subsection (1)(h) because the self-insured employer failed to obtain an experience modification factor.

(2) Notwithstanding the annual payment requirement in Subsection (1)(a), a self-insured employer whose total assessment obligation under Subsection (1)(a) for the preceding year was $10,000 or more shall pay the assessment in quarterly installments in the same manner provided in Section 59-9-104 and subject to the same penalty provided in Section 59-9-104 for not paying or underpaying an installment.

(3) (a) The State Tax Commission shall have access to all the records of the division for the purpose of auditing and collecting any amounts described in this section.

(b) Time periods for the State Tax Commission to allow a refund or make an

assessment shall be determined in accordance with Title 59, Chapter 1, Part 14, Assessment, Collections, and Refunds Act.

(4) (a) A review of appropriate use of job class assignment and calculation methodology may be conducted as directed by the division at any reasonable time as a condition of the self-insured employer's certification of paying compensation direct.

(b) The State Tax Commission shall make any records necessary for the review available to the commission.

(c) The commission shall make the results of any review available to the State Tax Commission.

Section 22. Section **35A-1-104.5** is amended to read:

35A-1-104.5. Strategic plan for health system reform.

The department shall work with the Department of Health, the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance, the Governor's Office of Economic Development, and the Legislature to develop the health system reform in accordance with Title 63M, Chapter 1, Part 25, Health System Reform Act.

Section 23. Section **35A-4-312** is amended to read:

35A-4-312. Records.

(1) (a) An employing unit shall keep true and accurate work records containing any information the department may prescribe by rule.

(b) A record shall be open to inspection and subject to being copied by the division or its authorized representatives at a reasonable time and as often as may be necessary.

(c) An employing unit shall make a record available in the state for three years after the calendar year in which the services are rendered.

(2) The division may require from an employing unit a sworn or unsworn report with respect to a person employed by the employing unit that the division considers necessary for the effective administration of this chapter.

(3) Except as provided in this section or in Sections 35A-4-103 and 35A-4-106, information obtained under this chapter or obtained from an individual may not be published or open to public inspection in any manner revealing the employing unit's or individual's identity.

(4) (a) The information obtained by the division under this section may not be used in court or admitted into evidence in an action or proceeding, except:

(i) in an action or proceeding arising out of this chapter;

(ii) if the Labor Commission enters into a written agreement with the division under Subsection (6)(b), in an action or proceeding by the Labor Commission to enforce:

(A) Title 34, Chapter 23, Employment of Minors;

(B) Title 34, Chapter 28, Payment of Wages;

(C) Title 34, Chapter 40, Utah Minimum Wage Act; or

(D) Title 34A, Utah Labor Code; or

(iii) under the terms of a court order obtained under Subsection 63G-2-202(7) and Section 63G-2-207.

(b) The information obtained by the division under this section shall be disclosed to:

(i) a party to an unemployment insurance hearing before an administrative law judge of the department or a review by the Workforce Appeals Board to the extent necessary for the proper presentation of the party's case; or

(ii) an employer, upon request in writing for any information concerning a claim for a benefit with respect to a former employee of the employer.

(5) The information obtained by the division under this section may be disclosed to:

(a) an employee of the department in the performance of the employee's duties in administering this chapter or other programs of the department;

(b) an employee of the Labor Commission for the purpose of carrying out the programs administered by the Labor Commission;

(c) an employee of the Department of Commerce for the purpose of carrying out the programs administered by the Department of Commerce;

(d) an employee of the governor's office or another state governmental agency administratively responsible for statewide economic development, to the extent necessary for economic development policy analysis and formulation;

(e) an employee of another governmental agency that is specifically identified and authorized by federal or state law to receive the information for the purposes stated in the law authorizing the employee of the agency to receive the information;

(f) an employee of a governmental agency or workers' compensation insurer to the extent the information will aid in:

(i) the detection or avoidance of duplicate, inconsistent, or fraudulent claims against:

(A) a workers' compensation program; or

(B) public assistance funds; or

(ii) the recovery of overpayments of workers' compensation or public assistance funds;

(g) an employee of a law enforcement agency to the extent the disclosure is necessary to avoid a significant risk to public safety or in aid of a felony criminal investigation;

(h) an employee of the State Tax Commission or the Internal Revenue Service for the purposes of:

(i) audit verification or simplification;

(ii) state or federal tax compliance;

(iii) verification of a code or classification of the:

(A) 1987 Standard Industrial Classification Manual of the federal Executive Office of the President, Office of Management and Budget; or

(B) 2002 North American Industry Classification System of the federal Executive Office of the President, Office of Management and Budget; and

(iv) statistics;

(i) an employee or contractor of the department or an educational institution, or other governmental entity engaged in workforce investment and development activities under the Workforce Investment Act of 1998 for the purpose of:

(i) coordinating services with the department;

(ii) evaluating the effectiveness of those activities; and

(iii) measuring performance;

(j) an employee of the Governor's Office of Economic Development, for the purpose of periodically publishing in the Directory of Business and Industry, the name, address, telephone number, number of employees by range, code or classification of an employer, and type of ownership of Utah employers;

(k) the public for any purpose following a written waiver by all interested parties of their rights to nondisclosure;

(l) an individual whose wage data is submitted to the department by an employer, so long as no information other than the individual's wage data and the identity of the employer who submitted the information is provided to the individual; or

(m) an employee of the [~~Insurance Department~~] Department of Commerce for the

purpose of administering Title 31A, Chapter 40, Professional Employer Organization Licensing Act.

(6) Disclosure of private information under Subsection (4)(a)(ii) or Subsection (5), with the exception of Subsections (5)(a) and (g), shall be made only if:

(a) the division determines that the disclosure will not have a negative effect on:

(i) the willingness of employers to report wage and employment information; or

(ii) the willingness of individuals to file claims for unemployment benefits; and

(b) the agency enters into a written agreement with the division in accordance with rules made by the department.

(7) (a) The employees of a division of the department other than the Workforce Development and Information Division and the Unemployment Insurance Division or an agency receiving private information from the division under this chapter are subject to the same requirements of privacy and confidentiality and to the same penalties for misuse or improper disclosure of the information as employees of the division.

(b) Use of private information obtained from the department by a person, or for a purpose other than one authorized in Subsection (4) or (5) violates Subsection 76-8-1301(4).

Section 24. Section **36-12-5** is amended to read:

36-12-5. Duties of interim committees.

(1) Except as otherwise provided by law, each interim committee shall:

(a) receive study assignments by resolution from the Legislature;

(b) receive study assignments from the Legislative Management Committee, created under Section 36-12-6;

(c) place matters on its study agenda after requesting approval of the study from the Legislative Management Committee, which request, if not disapproved by the Legislative Management Committee within 30 days of receipt of the request, the interim committee shall consider it approved and may proceed with the requested study;

(d) request research reports from the professional legislative staff pertaining to the committee's agenda of study;

(e) investigate and study possibilities for improvement in government services within its subject area;

(f) accept reports from the professional legislative staff and make recommendations for

legislative action with respect to such reports; and

(g) prepare and recommend to the Legislature a legislative program in response to the committee's study agenda.

(2) (a) As used in this Subsection (2):

(i) "Health insurance" is as defined in Section 31A-1-301.

(ii) "Health insurance mandate" means a mandatory obligation with respect to a coverage, benefit, or provider that, but for Title 31A, Insurance Code, would not be required for a policy of health insurance.

(iii) "Review committee" means:

(A) the Business and Labor Interim Committee; and

(B) the Health and Human Services Interim Committee.

(b) In addition to the duties established pursuant to Subsection (1), annually each review committee shall:

(i) identify the one or more health insurance mandates listed under Subsection (2)(d) that:

(A) are in effect for five or more years as of May 1; and

(B) have not been reviewed during the previous 10 years as of May 1;

(ii) select which of the one or more health insurance mandates identified under Subsection (2)(b)(i) that the review committee elects to review, subject to the direction of the Legislative Management Committee; and

(iii) review a health insurance mandate selected under Subsection (2)(b)(ii) to determine whether the health insurance mandate should be continued, modified, or repealed.

(c) The review under this Subsection (2) shall include:

(i) the estimated fiscal impact of the health insurance mandate on state and private health insurance; and

(ii) the purpose and effectiveness of the health insurance mandate.

(d) The [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, shall:

(i) provide a list of the health insurance mandates in this state in its annual report; and

(ii) assist in a review if requested by a review committee.

(3) Except as otherwise provided by law, reports and recommendations of the interim

committees shall be completed and made public prior to any legislative session at which the reports and recommendations are submitted. A copy of the reports and recommendations shall be mailed to each member or member-elect of the Legislature, to each elective state officer, and to the state library.

Section 25. Section **41-3-201** is amended to read:

41-3-201. Licenses required -- Restitution -- Education.

(1) As used in this section, "new applicant" means a person who is applying for a license that the person has not been issued during the previous licensing year.

(2) A person may not act as any of the following without having procured a license issued by the administrator:

(a) a dealer;

(b) salvage vehicle buyer;

(c) salesperson;

(d) manufacturer;

(e) transporter;

(f) dismantler;

(g) distributor;

(h) factory branch and representative;

(i) distributor branch and representative;

(j) crusher;

(k) remanufacturer; or

(l) body shop.

(3) (a) Except as provided in Subsection (3)(c), a person may not bid on or purchase a vehicle with a salvage certificate as defined in Section 41-1a-1001 at or through a motor vehicle auction unless the person is a licensed salvage vehicle buyer.

(b) Except as provided in Subsection (3)(c), a person may not offer for sale, sell, or exchange a vehicle with a salvage certificate as defined in Section 41-1a-1001 at or through a motor vehicle auction except to a licensed salvage vehicle buyer.

(c) A person may offer for sale, sell, or exchange a vehicle with a salvage certificate as defined in Section 41-1a-1001 at or through a motor vehicle auction:

(i) to an out-of-state or out-of-country purchaser not licensed under this section, but

that is authorized to do business in the domestic or foreign jurisdiction in which the person is domiciled or registered to do business; and

(ii) subject to the restriction in Subsection (3)(d), to an in-state purchaser not licensed under this section that:

(A) is registered to do business in Utah; and

(B) has a Utah sales tax license.

(d) An operator of a motor vehicle auction may only offer for sale, sell, or exchange five vehicles with a salvage certificate as defined in Section 41-1a-1001 at or through a motor vehicle auction in any 12 month period to an in-state purchaser that does not have a salvage vehicle buyer license issued in accordance with Subsection 41-3-202(15).

(e) (i) An in-state purchaser of a vehicle with a salvage certificate as defined in Section 41-1a-1001 that is purchased at or through a motor vehicle auction shall title the vehicle within 15 days of the purchase if the purchaser does not have a salvage vehicle buyer license, dealer license, body shop license, or dismantler license issued in accordance with Section 41-3-202.

(ii) An operator of a motor vehicle auction may not offer for sale, sell, or exchange additional vehicles with a salvage certificate as defined in Section 41-1a-1001 at or through a motor vehicle auction to a purchaser if notified that the purchaser has not titled previously purchased vehicles with a salvage certificate as required under Subsection (3)(e)(i).

(f) The commission may impose an administrative entrance fee established in accordance with the procedures and requirements of Section 63J-1-504 not to exceed $10 on a person not holding a license described in Subsection (3)(e)(i) that enters the physical premises of a motor vehicle auction for the purpose of viewing available salvage vehicles prior to an auction.

(4) (a) An operator of a motor vehicle auction shall keep a record of the sale of each salvage vehicle.

(b) A record described under Subsection (4)(a) shall contain:

(i) the purchaser's name and address; and

(ii) the year, make, and vehicle identification number for each salvage vehicle sold.

(c) An operator of a motor vehicle auction shall:

(i) retain the record described in this Subsection (4) for five years from the date of sale; and

(ii) make a record described in this Subsection (4) available for inspection by the division at the location of the motor vehicle auction during normal business hours.

(5) (a) An operator of a motor vehicle auction that sells a salvage vehicle to a person that is an out-of-country buyer shall:

(i) stamp on the face of the title so as not to obscure the name, date, or mileage statement the words "FOR EXPORT ONLY" in all capital, black letters; and

(ii) stamp in each unused reassignment space on the back of the title the words "FOR EXPORT ONLY."

(b) The words "FOR EXPORT ONLY" shall be:

(i) at least two inches wide; and

(ii) clearly legible.

(6) A supplemental license shall be secured by a dealer, manufacturer, remanufacturer, transporter, dismantler, crusher, or body shop for each additional place of business maintained by the licensee.

(7) A person who has been convicted of any law relating to motor vehicle commerce or motor vehicle fraud may not be issued a license unless full restitution regarding those convictions has been made.

(8) (a) The division may not issue a license to a new applicant for a new or used motor vehicle dealer license, a new or used motorcycle dealer license, or a small trailer dealer license unless the new applicant completes an eight-hour orientation class approved by the division that includes education on motor vehicle laws and rules.

(b) The approved costs of the orientation class shall be paid by the new applicant.

(c) The class shall be completed by the new applicant and the applicant's partners, corporate officers, bond indemnitors, and managers.

(d) (i) The division shall approve:

(A) providers of the orientation class; and

(B) costs of the orientation class.

(ii) A provider of an orientation class shall submit the orientation class curriculum to the division for approval prior to teaching the orientation class.

(iii) A provider of an orientation class shall include in the orientation materials:

(A) ethics training;

(B) motor vehicle title and registration processes;

(C) provisions of Title 13, Chapter 5, Unfair Practices Act, relating to motor vehicles;

(D) [~~Department of Insurance~~] Department of Commerce requirements relating to motor vehicles established under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

(E) Department of Public Safety requirements relating to motor vehicles;

(F) federal requirements related to motor vehicles as determined by the division; and

(G) any required disclosure compliance forms as determined by the division.

Section 26. Section **49-20-405** is amended to read:

49-20-405. Audit required -- Report to governor and Legislature.

The [~~Insurance Department~~] Department of Commerce acting under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, shall biennially audit the Public Employees' Trust Fund and programs authorized under this chapter and report its findings to the governor and the Legislature, but the [~~commissioner~~] Department of Commerce may accept the annual audited statement of the programs under this chapter in lieu of the biennial audit requirement.

Section 27. Section **58-9-302** is amended to read:

58-9-302. Qualifications for licensure.

(1) Each applicant for licensure as a funeral service director shall:

(a) submit an application in a form prescribed by the division;

(b) pay a fee as determined by the department under Section 63J-1-504;

(c) be of good moral character in that the applicant has not been convicted of:

(i) a first or second degree felony;

(ii) a misdemeanor involving moral turpitude; or

(iii) any other crime that when considered with the duties and responsibilities of a funeral service director is considered by the division and the board to indicate that the best interests of the public are not served by granting the applicant a license;

(d) have obtained a high school diploma or its equivalent or a higher education degree;

(e) have obtained an associate degree, or its equivalent, in mortuary science from a school of funeral service accredited by the American Board of Funeral Service Education or other accrediting body recognized by the [~~U.S.~~] United States Department of Education;

(f) have completed not less than 2,000 hours and 50 embalmings, over a period of not less than one year, of satisfactory performance in training as a licensed funeral service intern under the supervision of a licensed funeral service director; and

(g) obtain a passing score on examinations approved by the division in collaboration with the board.

(2) Each applicant for licensure as a funeral service intern shall:

(a) submit an application in a form prescribed by the division;

(b) pay a fee as determined by the department under Section 63J-1-504;

(c) be of good moral character in that the applicant has not been convicted of:

(i) a first or second degree felony;

(ii) a misdemeanor involving moral turpitude; or

(iii) any other crime that when considered with the duties and responsibilities of a funeral service intern is considered by the division and the board to indicate that the best interests of the public are not served by granting the applicant a license;

(d) have obtained a high school diploma or its equivalent or a higher education degree; and

(e) obtain a passing score on an examination approved by the division in collaboration with the board.

(3) Each applicant for licensure as a funeral service establishment and each funeral service establishment licensee shall:

(a) submit an application in a form prescribed by the division;

(b) pay a fee as determined by the department under Section 63J-1-504;

(c) have in place:

(i) an embalming room for preparing dead human bodies for burial or final disposition, which may serve one or more facilities operated by the applicant;

(ii) a refrigeration room that maintains a temperature of not more than 40 degrees fahrenheit for preserving dead human bodies prior to burial or final disposition, which may serve one or more facilities operated by the applicant; and

(iii) maintain at all times a licensed funeral service director who is responsible for the day-to-day operation of the funeral service establishment and who is personally available to perform the services for which the license is required;

(d) affiliate with a licensed preneed funeral arrangement sales agent or funeral service director if the funeral service establishment sells preneed funeral arrangements;

(e) file with the completed application a copy of each form of contract or agreement the applicant will use in the sale of preneed funeral arrangements; and

(f) provide evidence of appropriate licensure with the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, if the applicant intends to engage in the sale of any preneed funeral arrangements funded in whole or in part by an insurance policy or product to be sold by the provider or the provider's sales agent.

(4) Each applicant for licensure as a preneed funeral arrangement sales agent shall:

(a) submit an application in a form prescribed by the division;

(b) pay a fee as determined by the department under Section 63J-1-504;

(c) be of good moral character in that the applicant has not been convicted of:

(i) a first or second degree felony;

(ii) a misdemeanor involving moral turpitude; or

(iii) any other crime that when considered with the duties and responsibilities of a preneed funeral sales agent is considered by the division and the board to indicate that the best interests of the public are not served by granting the applicant a license;

(d) have obtained a high school diploma or its equivalent or a higher education degree;

(e) have obtained a passing score on an examination approved by the division in collaboration with the board;

(f) affiliate with a licensed funeral service establishment; and

(g) provide evidence of appropriate licensure with the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, if the applicant intends to engage in the sale of any preneed funeral arrangements funded in whole or in part by an insurance policy or product.

Section 28. Section **58-9-701** is amended to read:

58-9-701. Preneed contract requirements.

(1) (a) Every preneed funeral arrangement sold in Utah shall be evidenced by a written contract.

(b) The funeral service establishment shall maintain a copy of the contract until five

years after all of its obligations under the contract have been executed.

(2) Each preneed contract form shall:

(a) be written in clear and understandable language printed in an easy-to-read type size and style;

(b) bear the preprinted name, address, telephone number, and license number of the funeral service establishment obligated to provide the services under the contract terms;

(c) be sequentially numbered by contract form;

(d) clearly identify that the contract is a guaranteed product contract;

(e) provide that a trust is established in accordance with the provisions of Section 58-9-702;

(f) if the contract is funded by an insurance policy or product, provide that the insurance policy or product is filed with the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, and meets the requirements of Title 31A, Insurance Code; and

(g) conform to other standards created by rule under Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to protect the interests of buyers and potential buyers.

(3) A preneed contract shall provide for payment by the buyer in a form which may be liquidated by the funeral service establishment within 30 days after the day the funeral service establishment or sales agent receives the payment.

(4) A preneed contract may not be revocable by the funeral service establishment except:

(a) in the event of nonpayment; and

(b) under terms and conditions clearly set forth in the contract.

(5) (a) A preneed contract may not be revocable by the buyer or beneficiary except:

(i) in the event of:

(A) a substantial contract breach by the funeral service establishment; or

(B) substantial evidence that the funeral service establishment is or will be unable to provide the personal property or services to the beneficiary as provided under the contract; or

(ii) under terms and conditions clearly set forth in the contract.

(b) The contract shall contain a clear statement of the manner in which payments made on the contract shall be refunded to the buyer or beneficiary upon revocation by the beneficiary.

(6) (a) A preneed contract shall provide the buyer the option to require the funeral service establishment to furnish a written disclosure to a person who does not live at the same residence as the buyer.

(b) The buyer may choose:

(i) a full disclosure containing a copy of the entire preneed contract;

(ii) a partial disclosure informing the recipient of:

(A) the existence of a preneed contract; and

(B) the name, address, telephone number, and license number of the funeral service establishment obligated to provide the services under the preneed contract; or

(iii) not to require the funeral service establishment to furnish a written disclosure to another person.

Section 29. Section **58-56-17** is amended to read:

58-56-17. Fees on sale -- Escrow agents -- Sales tax.

(1) A dealer shall collect and remit a fee of $75 to the division for each factory built home the dealer sells that, as of the date of the sale, has not been permanently affixed to real property and converted to real property as provided in Section 70D-2-401. The fee shall be payable within 30 days following the close of each calendar quarter for all units sold during that calendar quarter. The fee shall be deposited in a restricted account as provided in Section 58-56-17.5.

(2) A principal real estate broker, associate broker, or sales agent exempt from registration as a dealer under Section 58-56-16 who sells a factory built home that has not been permanently affixed to real property shall close the sale only through a qualified escrow agent in this state registered with the [~~Insurance Department or the~~] Department of Financial Institutions or the Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance.

(3) An escrow agent through which a sale is closed under Subsection (2) shall remit all required sales tax to the state.

Section 30. Section **59-9-105** is amended to read:

59-9-105. Tax on certain insurers to pay for relative value study and other publications or services.

(1) Each insurer providing coverage for motor vehicle liability, uninsured motorist, and

personal injury protection shall pay to the State Tax Commission on or before March 31 of each year, a tax of .01% on the total premiums received for these coverages during the preceding calendar year from policies covering motor vehicle risks in this state.

(2) The taxable premium under this section shall be reduced by all premiums returned or credited to policyholders on direct business subject to tax in this state.

(3) All money received by the state under this section shall be deposited in the General Fund as a dedicated credit for the purpose of providing funds to pay for any costs and expenses incurred by the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance:

(a) in conducting, maintaining, and administering the relative value study referred to in Section 31A-22-307;

(b) to prepare, publish, and distribute publications relating to insurance and consumers of insurance as provided in Section 31A-2-208; and

(c) in providing the services of the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, through the use of:

(i) electronic commerce; and

(ii) other information technology.

Section 31. Section **59-10-1023** is amended to read:

59-10-1023. Nonrefundable tax credit for amounts paid under a health benefit plan.

(1) As used in this section:

(a) "Claimant with dependents" means a claimant:

(i) regardless of the claimant's filing status for purposes of filing a federal individual income tax return for the taxable year; and

(ii) who claims one or more dependents under Section 151, Internal Revenue Code, as allowed on the claimant's federal individual income tax return for the taxable year.

(b) "Eligible insured individual" means:

(i) the claimant who is insured under a health benefit plan;

(ii) the spouse of the claimant described in Subsection (1)(b)(i) if:

(A) the claimant files a single return jointly under this chapter with the claimant's spouse for the taxable year; and

(B) the spouse is insured under the health benefit plan described in Subsection (1)(b)(i); or

(iii) a dependent of the claimant described in Subsection (1)(b)(i) if:

(A) the claimant claims the dependent under Section 151, Internal Revenue Code, as allowed on the claimant's federal individual income tax return for the taxable year; and

(B) the dependent is insured under the health benefit plan described in Subsection (1)(b)(i).

(c) "Excluded expenses" means an amount a claimant pays for insurance offered under a health benefit plan for a taxable year if:

(i) the claimant claims a tax credit for that amount under Section 35, Internal Revenue Code:

(A) on the claimant's federal individual income tax return for the taxable year; and

(B) with respect to an eligible insured individual;

(ii) the claimant deducts that amount under Section 162 or 213, Internal Revenue Code:

(A) on the claimant's federal individual income tax return for the taxable year; and

(B) with respect to an eligible insured individual; or

(iii) the claimant excludes that amount from gross income under Section 106 or 125, Internal Revenue Code, with respect to an eligible insured individual.

(d) (i) "Health benefit plan" is as defined in Section 31A-1-301.

(ii) "Health benefit plan" does not include equivalent self-insurance as defined [~~by the Insurance Department~~] by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, by the Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance.

(e) "Joint claimant with no dependents" means a husband and wife who:

(i) file a single return jointly under this chapter for the taxable year; and

(ii) do not claim a dependent under Section 151, Internal Revenue Code, on the husband's and wife's federal individual income tax return for the taxable year.

(f) "Single claimant with no dependents" means:

(i) a single individual who:

(A) files a single federal individual income tax return for the taxable year; and

(B) does not claim a dependent under Section 151, Internal Revenue Code, on the single individual's federal individual income tax return for the taxable year;

(ii) a head of household:

(A) as defined in Section 2(b), Internal Revenue Code, who files a single federal individual income tax return for the taxable year; and

(B) who does not claim a dependent under Section 151, Internal Revenue Code, on the head of household's federal individual income tax return for the taxable year; or

(iii) a married individual who:

(A) does not file a single federal individual income tax return jointly with that married individual's spouse for the taxable year; and

(B) does not claim a dependent under Section 151, Internal Revenue Code, on that married individual's federal individual income tax return for the taxable year.

(2) Subject to Subsection (3), and except as provided in Subsection (4), for taxable years beginning on or after January 1, 2009, a claimant may claim a nonrefundable tax credit equal to the product of:

(a) the difference between:

(i) the total amount the claimant pays during the taxable year for:

(A) insurance offered under a health benefit plan; and

(B) an eligible insured individual; and

(ii) excluded expenses; and

(b) 5%.

(3) The maximum amount of a tax credit described in Subsection (2) a claimant may claim on a return for a taxable year is:

(a) for a single claimant with no dependents, $300;

(b) for a joint claimant with no dependents, $600; or

(c) for a claimant with dependents, $900.

(4) A claimant may not claim a tax credit under this section if the claimant is eligible to participate in insurance offered under a health benefit plan maintained and funded in whole or in part by:

(a) the claimant's employer; or

(b) another person's employer.

(5) A claimant may not carry forward or carry back a tax credit under this section.

Section 32. Section **63A-5-205** is amended to read:

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

(1) As used in this section:

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

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

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

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

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

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

(e) "Qualified health insurance coverage" means at the time the contract is entered into or renewed:

(i) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(A) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(e)(i):

(I) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(Aa) the deductible is $750 per individual and $2,250 per family; and

(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a

deductible that is either:

(I) the lowest deductible permitted for a federally qualified high deductible health plan; or

(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(B) an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.

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

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

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

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

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

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

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

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

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

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

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

(iv) to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the threshold required by Subsection (3)(a).

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

circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

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

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

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

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

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

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

(f) The division shall adopt administrative rules:

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

(ii) in coordination with:

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

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

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

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

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

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

(iii) which establish:

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

(I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)

or (ii) more than twice in any 12-month period; and

(II) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(Aa) the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

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

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

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

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

(II) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(III) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

(i) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

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

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

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

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

Section 33. Section **63C-6-101** is amended to read:

63C-6-101. Creation of commission -- Membership -- Appointment -- Vacancies.

(1) There is created the Utah Seismic Safety Commission consisting of 15 members, designated as follows:

(a) the director of the Division of Homeland Security or [~~his~~] the director's designee;

(b) the director of the Utah Geological Survey or [~~his~~] the director's designee;

(c) the director of the University of Utah Seismograph Stations or [~~his~~] the director's designee;

(d) the executive director of the Utah League of Cities and Towns or [~~his~~] the executive director's designee;

(e) a representative from the Structural Engineers Association of Utah biannually selected by its membership;

(f) the director of the Division of Facilities Construction and Management or [~~his~~] the director's designee;

(g) the executive director of the Department of Transportation or [~~his~~] the executive director's designee;

(h) the State Planning Coordinator or [~~his~~] the State Planning Coordinator's designee;

(i) a representative from the American Institute of Architects, Utah Section;

(j) a representative from the American Society of Civil Engineers, Utah Section;

(k) a member of the House of Representatives appointed biannually by the speaker of the House;

(l) a member of the Senate appointed biannually by the president of the Senate;

(m) the [~~commissioner of the Department of Insurance or his~~] executive director of the Department of Commerce, or the executive director's designee;

(n) a representative from the Association of Contingency Planners, Utah Chapter, biannually selected by its membership; and

(o) a representative from the American Public Works Association, Utah Chapter, biannually selected by its membership.

(2) The commission shall annually select one of its members to serve as chair of the commission.

(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

Section 34. Section **63C-9-403** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

(c) "Qualified health insurance coverage" means at the time the contract is entered into or renewed:

(i) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(A) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(Aa) the deductible is $750 per individual and $2,250 per family; and

(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a deductible that is either:

(I) the lowest deductible permitted for a federally qualified high deductible health plan; or

(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(B) an out-of-pocket maximum that does not exceed three times the amount of the

annual deductible; and

(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the executive director compliance with this section which shall include:

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

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

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

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

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

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

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

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

Section 35. Section **63G-2-302** is amended to read:

63G-2-302. Private records.

(1) The following records are private:

(a) records concerning an individual's eligibility for unemployment insurance benefits, social services, welfare benefits, or the determination of benefit levels;

(b) records containing data on individuals describing medical history, diagnosis, condition, treatment, evaluation, or similar medical data;

(c) records of publicly funded libraries that when examined alone or with other records identify a patron;

(d) records received by or generated by or for:

(i) the Independent Legislative Ethics Commission, except for:

(A) the commission's summary data report that is required under legislative rule; and

(B) any other document that is classified as public under legislative rule; or

(ii) a Senate or House Ethics Committee in relation to the review of ethics complaints, unless the record is classified as public under legislative rule;

(e) records received or generated for a Senate confirmation committee concerning character, professional competence, or physical or mental health of an individual:

(i) if prior to the meeting, the chair of the committee determines release of the records:

(A) reasonably could be expected to interfere with the investigation undertaken by the committee; or

(B) would create a danger of depriving a person of a right to a fair proceeding or impartial hearing; and

(ii) after the meeting, if the meeting was closed to the public;

(f) employment records concerning a current or former employee of, or applicant for employment with, a governmental entity that would disclose that individual's home address,

home telephone number, Social Security number, insurance coverage, marital status, or payroll deductions;

(g) records or parts of records under Section 63G-2-303 that a current or former employee identifies as private according to the requirements of that section;

(h) that part of a record indicating a person's Social Security number or federal employer identification number if provided under Section 31A-23a-104, 31A-25-202, 31A-26-202, 58-1-301, 61-1-4, or 61-2f-203;

(i) that part of a voter registration record identifying a voter's driver license or identification card number, Social Security number, or last four digits of the Social Security number;

(j) a record that:

(i) contains information about an individual;

(ii) is voluntarily provided by the individual; and

(iii) goes into an electronic database that:

(A) is designated by and administered under the authority of the Chief Information Officer; and

(B) acts as a repository of information about the individual that can be electronically retrieved and used to facilitate the individual's online interaction with a state agency;

(k) information provided to the [~~Commissioner of Insurance~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, under:

(i) Subsection 31A-23a-115(2)(a);

(ii) Subsection 31A-23a-302(3); or

(iii) Subsection 31A-26-210(3);

(l) information obtained through a criminal background check under Title 11, Chapter 40, Criminal Background Checks by Political Subdivisions Operating Water Systems;

(m) information provided by an offender that is:

(i) required by the registration requirements of Section 77-27-21.5; and

(ii) not required to be made available to the public under Subsection 77-27-21.5(27); and

(n) a statement and any supporting documentation filed with the attorney general in

accordance with Section 34-45-107, if the federal law or action supporting the filing involves homeland security.

(2) The following records are private if properly classified by a governmental entity:

(a) records concerning a current or former employee of, or applicant for employment with a governmental entity, including performance evaluations and personal status information such as race, religion, or disabilities, but not including records that are public under Subsection 63G-2-301(2)(b) or 63G-2-301(3)(o), or private under Subsection (1)(b);

(b) records describing an individual's finances, except that the following are public:

(i) records described in Subsection 63G-2-301(2);

(ii) information provided to the governmental entity for the purpose of complying with a financial assurance requirement; or

(iii) records that must be disclosed in accordance with another statute;

(c) records of independent state agencies if the disclosure of those records would conflict with the fiduciary obligations of the agency;

(d) other records containing data on individuals the disclosure of which constitutes a clearly unwarranted invasion of personal privacy;

(e) records provided by the United States or by a government entity outside the state that are given with the requirement that the records be managed as private records, if the providing entity states in writing that the record would not be subject to public disclosure if retained by it; and

(f) any portion of a record in the custody of the Division of Aging and Adult Services, created in Section 62A-3-102, that may disclose, or lead to the discovery of, the identity of a person who made a report of alleged abuse, neglect, or exploitation of a vulnerable adult.

(3) (a) As used in this Subsection (3), "medical records" means medical reports, records, statements, history, diagnosis, condition, treatment, and evaluation.

(b) Medical records in the possession of the University of Utah Hospital, its clinics, doctors, or affiliated entities are not private records or controlled records under Section 63G-2-304 when the records are sought:

(i) in connection with any legal or administrative proceeding in which the patient's physical, mental, or emotional condition is an element of any claim or defense; or

(ii) after a patient's death, in any legal or administrative proceeding in which any party

relies upon the condition as an element of the claim or defense.

(c) Medical records are subject to production in a legal or administrative proceeding according to state or federal statutes or rules of procedure and evidence as if the medical records were in the possession of a nongovernmental medical care provider.

Section 36. Section **63J-1-201** is amended to read:

63J-1-201. Governor to submit budget to Legislature -- Contents -- Preparation -- Appropriations based on current tax laws and not to exceed estimated revenues.

(1) The governor shall deliver, not later than 30 days before the date the Legislature convenes in the annual general session, a confidential draft copy of the governor's proposed budget recommendations to the Office of the Legislative Fiscal Analyst.

(2) (a) The governor shall, within the first three days of the annual general session of the Legislature, submit to the presiding officer of each house of the Legislature:

(i) a proposed budget for the ensuing fiscal year;

(ii) a schedule for all of the proposed appropriations of the budget, with each appropriation clearly itemized and classified;

(iii) the statement described in Subsection (2)(c); and

(iv) as applicable, a document showing proposed expenditures and estimated revenues that are based on changes in state tax laws or rates.

(b) The proposed budget shall include:

(i) a projection of estimated revenues and expenditures for the next fiscal year;

(ii) the source of all direct, indirect, and in-kind matching funds for all federal grants or assistance programs included in the budget;

(iii) a complete plan of proposed expenditures and estimated revenues for the next fiscal year that is based upon the current fiscal year state tax laws and rates;

(iv) an itemized estimate of the proposed appropriations for:

(A) the Legislative Department as certified to the governor by the president of the Senate and the speaker of the House;

(B) the Executive Department;

(C) the Judicial Department as certified to the governor by the state court administrator;

(D) payment and discharge of the principal and interest of the indebtedness of the state;

(E) the salaries payable by the state under the Utah Constitution or under law for the lease agreements planned for the next fiscal year;

(F) other purposes that are set forth in the Utah Constitution or under law; and

(G) all other appropriations;

(v) for each line item, the average annual dollar amount of staff funding associated with all positions that were vacant during the last fiscal year; and

(vi) deficits or anticipated deficits.

(c) The budget shall be accompanied by a statement showing:

(i) the revenues and expenditures for the last fiscal year;

(ii) the current assets, liabilities, and reserves, surplus or deficit, and the debts and funds of the state;

(iii) an estimate of the state's financial condition as of the beginning and the end of the period covered by the budget;

(iv) a complete analysis of lease with an option to purchase arrangements entered into by state agencies;

(v) the recommendations for each state agency for new full-time employees for the next fiscal year, which shall also be provided to the State Building Board as required by Subsection 63A-5-103(2);

(vi) any explanation that the governor may desire to make as to the important features of the budget and any suggestion as to methods for the reduction of expenditures or increase of the state's revenue; and

(vii) information detailing certain fee increases as required by Section 63J-1-504.

(3) (a) (i) For the purpose of preparing and reporting the proposed budget, the governor shall require the proper state officials, including all public and higher education officials, all heads of executive and administrative departments and state institutions, bureaus, boards, commissions, and agencies expending or supervising the expenditure of the state money, and all institutions applying for state money and appropriations, to provide itemized estimates of revenues and expenditures.

(ii) The governor may also require other information under these guidelines and at times as the governor may direct, which may include a requirement for program productivity and performance measures, where appropriate, with emphasis on outcome indicators.

(b) The governor may require representatives of public and higher education, state departments and institutions, and other institutions or individuals applying for state appropriations to attend budget meetings.

(c) (i) (A) In submitting the budgets for the Departments of Health and Human Services and the Office of the Attorney General, the governor shall consider a separate recommendation in the governor's budget for funds to be contracted to:

(I) local mental health authorities under Section 62A-15-110;

(II) local substance abuse authorities under Section 62A-15-110;

(III) area agencies under Section 62A-3-104.2;

(IV) programs administered directly by and for operation of the Divisions of Substance Abuse and Mental Health and Aging and Adult Services;

(V) local health departments under Title 26A, Chapter 1, Local Health Departments; and

(VI) counties for the operation of Children's Justice Centers under Section 67-5b-102.

(B) In the governor's budget recommendations under Subsections (3)(c)(i)(A)(I), (II), and (III), the governor shall consider an amount sufficient to grant local health departments, local mental health authorities, local substance abuse authorities, and area agencies the same percentage increase for wages and benefits that the governor includes in the governor's budget for persons employed by the state.

(C) If the governor does not include in the governor's budget an amount sufficient to grant the increase described in Subsection (3)(c)(i)(B), the governor shall include a message to the Legislature regarding the governor's reason for not including that amount.

(ii) (A) In submitting the budget for the Department of Agriculture, the governor shall consider an amount sufficient to grant local conservation districts and Utah Association of Conservation District employees the same percentage increase for wages and benefits that the governor includes in the governor's budget for persons employed by the state.

(B) If the governor does not include in the governor's budget an amount sufficient to grant the increase described in Subsection (3)(c)(ii)(A), the governor shall include a message to the Legislature regarding the governor's reason for not including that amount.

(iii) (A) In submitting the budget for the Utah State Office of Rehabilitation and the Division of Services for People with Disabilities, the Division of Child and Family Services,

and the Division of Juvenile Justice Services within the Department of Human Services, the governor shall consider an amount sufficient to grant employees of corporations that provide direct services under contract with those divisions, the same percentage increase for cost-of-living that the governor includes in the governor's budget for persons employed by the state.

(B) If the governor does not include in the governor's budget an amount sufficient to grant the increase described in Subsection (3)(c)(iii)(A), the governor shall include a message to the Legislature regarding the governor's reason for not including that amount.

(iv) (A) The Families, Agencies, and Communities Together Council may propose a budget recommendation to the governor for collaborative service delivery systems operated under Section 63M-9-402, as provided under Subsection 63M-9-201(4)(e).

(B) The Legislature may, through a specific program schedule, designate funds appropriated for collaborative service delivery systems operated under Section 63M-9-402.

(v) The governor shall include in the governor's budget the state's portion of the budget for the Utah Communications Agency Network established in Title 63C, Chapter 7, Utah Communications Agency Network Act.

(vi) (A) The governor shall include a separate recommendation in the governor's budget for funds to maintain the operation and administration of the Utah Comprehensive Health Insurance Pool.

(B) In making the recommendation, the governor may consider:

(I) actuarial analysis of growth or decline in enrollment projected over a period of at least three years;

(II) actuarial analysis of the medical and pharmacy claims costs projected over a period of at least three years;

(III) the annual Medical Care Consumer Price Index;

(IV) the annual base budget for the pool established by the Commerce and Revenue Appropriations Subcommittee for each fiscal year;

(V) the growth or decline in insurance premium taxes and fees collected by the State Tax Commission and the [~~Insurance Department~~] Department of Commerce acting under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance; and

(VI) the availability of surplus General Fund revenue under Section 63J-1-312 and

Subsection 59-14-204(5)(b).

(d) (i) The governor may revise all estimates, except those relating to the Legislative Department, the Judicial Department, and those providing for the payment of principal and interest to the state debt and for the salaries and expenditures specified by the Utah Constitution or under the laws of the state.

(ii) The estimate for the Legislative Department, as certified by the presiding officers of both houses, shall be included in the budget without revision by the governor.

(iii) The estimate for the Judicial Department, as certified by the state court administrator, shall also be included in the budget without revision, but the governor may make separate recommendations on the estimate.

(e) The total appropriations requested for expenditures authorized by the budget may not exceed the estimated revenues from taxes, fees, and all other sources for the next ensuing fiscal year.

(4) In considering the factors in Subsections (3)(c)(vi)(B)(I), (II), and (III) and Subsections (5)(b)(ii)(A), (B), and (C), the governor and the Legislature may consider the actuarial data and projections prepared for the board of the Utah Comprehensive Health Insurance Pool as it develops its financial statements and projections for each fiscal year.

(5) (a) In adopting a budget for each fiscal year, the Legislature shall consider an amount sufficient to grant local health departments, local mental health authorities, local substance abuse authorities, area agencies on aging, conservation districts, and Utah Association of Conservation District employees the same percentage increase for wages and benefits that is included in the budget for persons employed by the state.

(b) (i) In adopting a budget each year for the Utah Comprehensive Health Insurance Pool, the Legislature shall determine an amount that is sufficient to fund the pool for each fiscal year.

(ii) When making a determination under Subsection (5)(b)(i), the Legislature shall consider factors it determines are appropriate, which may include:

(A) actuarial analysis of growth or decline in enrollment projected over a period of at least three years;

(B) actuarial analysis of the medical and pharmacy claims costs projected over a period of at least three years;

(C) the annual Medical Care Consumer Price Index;

(D) the annual base budget for the pool established by the Commerce and Revenue Appropriations Subcommittee for each fiscal year;

(E) the growth or decline in insurance premium taxes and fees collected by the tax commission and the [~~insurance department~~] Department of Commerce acting under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, from the previous fiscal year; and

(F) the availability of surplus General Fund revenue under Section 63J-1-312 and Subsection 59-14-204(5)(b).

(iii) The funds appropriated by the Legislature to fund the Utah Comprehensive Health Insurance Pool as determined under Subsection (5)(b)(i):

(A) shall be deposited into the fund established by Section 31A-29-120; and

(B) are restricted and are to be used to maintain the operation, administration, and management of the Utah Comprehensive Health Insurance Pool created by Section 31A-29-104.

(6) If any item of the budget as enacted is held invalid upon any ground, the invalidity does not affect the budget itself or any other item in it.

Section 37. Section **63K-1-102** is amended to read:

63K-1-102. Definitions.

(1) (a) "Absent" means:

(i) not physically present or not able to be communicated with for 48 hours; or

(ii) for local government officers, as defined by local ordinances.

(b) "Absent" does not include a person who can be communicated with via telephone, radio, or telecommunications.

(2) "Attack" means a nuclear, conventional, biological, or chemical warfare action against the United States of America or this state.

(3) "Department" means the Department of Administrative Services, the Department of Agriculture and Food, the Alcoholic Beverage Control Commission, the Department of Commerce, the Department of Community and Culture, the Department of Corrections, the Department of Environmental Quality, the Department of Financial Institutions, the Department of Health, the Department of Human Resource Management, the Department of

Workforce Services, the Labor Commission, the National Guard, [~~the Department of Insurance,~~] the Department of Natural Resources, the Department of Public Safety, the Public Service Commission, the Department of Human Services, the State Tax Commission, the Department of Technology Services, the Department of Transportation, any other major administrative subdivisions of state government, the State Board of Education, the State Board of Regents, the Utah Housing Corporation, the Workers' Compensation Fund, the State Retirement Board, and each institution of higher education within the system of higher education.

(4) "Disaster" means a situation causing, or threatening to cause, widespread damage, social disruption, or injury or loss of life or property resulting from attack, internal disturbance, natural phenomenon, or technological hazard.

(5) "Division" means the Division of Homeland Security established in Title 53, Chapter 2, Part 1, Homeland Security Act.

(6) "Emergency interim successor" means a person designated by this chapter to exercise the powers and discharge the duties of an office when the person legally exercising the powers and duties of the office is unavailable.

(7) "Executive director" means the person with ultimate responsibility for managing and overseeing the operations of each department, however denominated.

(8) "Internal disturbance" means a riot, prison break, terrorism, or strike.

(9) "Natural phenomenon" means any earthquake, tornado, storm, flood, landslide, avalanche, forest or range fire, drought, epidemic, or other catastrophic event.

(10) (a) "Office" includes all state and local offices, the powers and duties of which are defined by constitution, statutes, charters, optional plans, ordinances, articles, or by-laws.

(b) "Office" does not include the office of governor or the legislative or judicial offices.

(11) "Place of governance" means the physical location where the powers of an office are being exercised.

(12) "Political subdivision" includes counties, cities, towns, townships, districts, authorities, and other public corporations and entities whether organized and existing under charter or general law.

(13) "Political subdivision officer" means a person holding an office in a political subdivision.

(14) "State officer" means the attorney general, the state treasurer, the state auditor, and the executive director of each department.

(15) "Technological hazard" means any hazardous materials accident, mine accident, train derailment, air crash, radiation incident, pollution, structural fire, or explosion.

(16) "Unavailable" means:

(a) absent from the place of governance during a disaster that seriously disrupts normal governmental operations, whether or not that absence or inability would give rise to a vacancy under existing constitutional or statutory provisions; or

(b) as otherwise defined by local ordinance.

Section 38. Section **63M-1-2503** is amended to read:

63M-1-2503. Duties related to health system reform.

The Governor's Office of Economic Development shall coordinate the efforts of the Office of Consumer Health Services, the Department of Health, the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance, and the Department of Workforce Services to assist the Legislature with developing the state's strategic plan for health system reform described in Section 63M-1-2505.

Section 39. Section **63M-1-2504** is amended to read:

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

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:

(i) is capable of providing access to private and government health insurance websites and their electronic application forms and submission procedures;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange by an insurer for the:

(A) small employer group market;

(B) the individual market; and

(C) the defined contribution arrangement market; and

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others by educating employers and insurers about collection services available through private vendors, including financial institutions;

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars;

(d) periodically convene health care providers, payers, and consumers to monitor the progress being made regarding demonstration projects for health care delivery and payment reform;

(e) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the defined contribution arrangement market on the Health Insurance Exchange; and

(f) report to the Business and Labor Interim Committee and the Health System Reform Task Force prior to November 1, 2010, and prior to the Legislative interim day in November of each year thereafter regarding:

(i) the operations of the Health Insurance Exchange required by this chapter; and

(ii) the progress of the demonstration projects for health care payment and delivery reform.

(3) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, or health insurance producers;

(ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

(iii) act as an appeals entity for resolving disputes between a health insurer and an insured; and

(b) may establish and collect a fee in accordance with Section 63J-1-504 for the transaction cost of:

(i) processing an application for a health benefit plan from the Internet portal to an

insurer; and

(ii) accepting, processing, and submitting multiple premium payment sources.

Section 40. Section **63M-1-2506** is amended to read:

63M-1-2506. Health benefit plan information on Health Insurance Exchange -- Insurer transparency.

(1) (a) The office shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that:

(i) establish uniform electronic standards for:

(A) a health insurer to use when:

(I) transmitting information to:

(Aa) the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, under Subsection 31A-22-613.5(2)(a)(ii); and

(Bb) the Health Insurance Exchange as required by this section;

(II) receiving information from the Health Insurance Exchange; and

(III) receiving or transmitting the universal health application to or from the Health Insurance Exchange;

(B) facilitating the transmission and receipt of premium payments from multiple sources in the defined contribution arrangement market; and

(C) the use of the uniform health insurance application required by Section 31A-22-635 on the Health Insurance Exchange;

(ii) designate the level of detail that would be helpful for a concise consumer comparison of the items described in Subsections (4) and (5) on the Health Insurance Exchange;

(iii) assist the risk adjuster board created under Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on the Health Insurance Exchange with the determination of when an employer is eligible to participate in the Health Insurance Exchange under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements; and

(iv) create an advisory board to advise the exchange concerning the operation of the exchange and transparency issues with the following members:

(A) two health producers who are registered with the Health Insurance Exchange;

(B) two consumers;

(C) one representative from a large insurer who participates on the exchange;

(D) one representative from a small insurer who participates on the exchange;

(E) one representative from the [~~Insurance Department~~] Department of Commerce, which may delegate this function to the Division of Insurance; and

(F) one representative from the Department of Health.

(b) The office shall post or facilitate the posting of:

(i) the information required by this section on the Health Insurance Exchange created by this part; and

(ii) links to websites that provide cost and quality information from the Department of Health Data Committee or neutral entities with a broad base of support from the provider and payer communities.

(2) A health insurer shall use the uniform electronic standards when transmitting information to the Health Insurance Exchange or receiving information from the Health Insurance Exchange.

(3) (a) (i) An insurer who participates in the defined contribution arrangement market under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans offered in the defined contribution arrangement market on the Health Insurance Exchange and shall comply with the provisions of this section.

(ii) Beginning January 1, 2013, an insurer who offers a health benefit plan to a small employer group in the state shall:

(A) post the health benefit plans in which the insurer is enrolling new groups on the Health Insurance Exchange; and

(B) comply with the provisions of this section.

(b) An insurer who offers individual health benefit plans under Title 31A, Chapter 30, Part 1, Individual and Small Employer Group:

(i) shall post on the Health Insurance Exchange the basic benefit plan required by Section 31A-22-613.5; and

(ii) may publish on the Health Insurance Exchange any other health benefit plans that it offers in the individual market.

(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:

(i) shall comply with the provisions of this section for every health benefit plan it posts on the Health Insurance Exchange; and

(ii) may not offer products on the Health Insurance Exchange that are not health benefit plans.

(4) A health insurer shall provide the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance Exchange:

(a) plan design, benefits, and options offered by the health benefit plan including state mandates the plan does not cover;

(b) provider networks;

(c) wellness programs and incentives; and

(d) descriptions of prescription drug benefits, exclusions, or limitations.

(5) (a) An insurer offering any health benefit plan in the state shall submit the information described in Subsection (5)(b) to the [~~Insurance Department~~] Department of Commerce in the electronic format required by Subsection (1).

(b) An insurer who offers a health benefit plan in the state shall submit to the Health Insurance Exchange the following operational measures:

(i) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and

(ii) for all health benefit plans offered by the insurer in the state, the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).

(c) The [~~Insurance Department~~] Department of Commerce shall forward to the Health Insurance Exchange the information submitted by an insurer in accordance with this section and Section 31A-22-613.5.

(6) The [~~Insurance Department~~] Department of Commerce shall post on the Health Insurance Exchange the [~~Insurance Department's~~] Department of Commerce's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each carrier shall be based on methodology established by the [~~Insurance Department~~] Department of Commerce by administrative rule and shall be updated each calendar year.

(7) The commissioner may request information from an insurer under Section

31A-22-613.5 to verify the data submitted to the [~~Insurance Department~~] Department of Commerce and to the Health Insurance Exchange under this section.

(8) A health insurer shall accept and process an application for a health benefit plan from the Health Insurance Exchange in accordance with this section and Section 31A-22-635.

Section 41. Section **67-19-6.7** is amended to read:

67-19-6.7. Overtime policies for state employees.

(1) As used in this section:

(a) "Accrued overtime hours" means:

(i) for nonexempt employees, overtime hours earned during a fiscal year that, at the end of the fiscal year, have not been paid and have not been taken as time off by the nonexempt state employee who accrued them; and

(ii) for exempt employees, overtime hours earned during an overtime year.

(b) "Appointed official" means:

(i) each department executive director and deputy director, each division director, and each member of a board or commission; and

(ii) any other person employed by a department who is appointed by, or whose appointment is required by law to be approved by, the governor and who:

(A) is paid a salary by the state; and

(B) who exercises managerial, policy-making, or advisory responsibility.

(c) "Department" means the Department of Administrative Services, the Department of Corrections, the Department of Financial Institutions, the Department of Alcoholic Beverage Control, [~~the Insurance Department,~~] the Public Service Commission, the Labor Commission, the Department of Agriculture and Food, the Department of Human Services, the State Board of Education, the Department of Natural Resources, the Department of Technology Services, the Department of Transportation, the Department of Commerce, the Department of Workforce Services, the State Tax Commission, the Department of Community and Culture, the Department of Health, the National Guard, the Department of Environmental Quality, the Department of Public Safety, the Department of Human Resource Management, the Commission on Criminal and Juvenile Justice, all merit employees except attorneys in the Office of the Attorney General, merit employees in the Office of the State Treasurer, merit employees in the Office of the State Auditor, Department of Veterans' Affairs, and the Board of

Pardons and Parole.

(d) "Elected official" means any person who is an employee of the state because the person was elected by the registered voters of Utah to a position in state government.

(e) "Exempt employee" means a state employee who is exempt as defined by the Fair Labor Standards Act of 1978, 29 U.S.C. [~~Section~~] Sec. 201 et seq.

(f) "FLSA" means the Fair Labor Standards Act of 1978, 29 U.S.C. [~~Section~~] Sec. 201 et seq.

(g) "FLSA agreement" means the agreement authorized by the Fair Labor Standards Act of 1978, 29 U.S.C. [~~Section~~] Sec. 201 et seq., by which a nonexempt employee elects the form of compensation the nonexempt employee will receive for overtime.

(h) "Nonexempt employee" means a state employee who is nonexempt as defined by the Department of Human Resource Management applying FLSA requirements.

(i) "Overtime" means actual time worked in excess of the employee's defined work period.

(j) "Overtime year" means the year determined by a department under Subsection (4)(b) at the end of which an exempt employee's accrued overtime lapses.

(k) "State employee" means every person employed by a department who is not:

(i) an appointed official;

(ii) an elected official;

(iii) a member of a board or commission who is paid only on a per diem or travel expenses basis; or

(iv) employed on a contractual basis at the State Office of Education.

(l) "Uniform annual date" means the date when an exempt employee's accrued overtime lapses.

(m) "Work period" means:

(i) for all nonexempt employees, except law enforcement and hospital employees, a consecutive seven day 24 hour work period of 40 hours;

(ii) for all exempt employees, a 14 day, 80 hour payroll cycle; and

(iii) for nonexempt law enforcement and hospital employees, the period established by each department by rule for those employees according to the requirements of the Fair Labor Standards Act of 1978, 29 U.S.C. [~~Section~~] Sec. 201 et seq.

(2) Each department shall compensate each state employee who works overtime by complying with the requirements of this section.

(3) (a) Each department shall negotiate and obtain a signed FLSA agreement from each nonexempt employee.

(b) In the FLSA agreement, the nonexempt employee shall elect either to be compensated for overtime by:

(i) taking time off work at the rate of one and one-half hour off for each overtime hour worked; or

(ii) being paid for the overtime worked at the rate of one and one-half times the rate per hour that the state employee receives for nonovertime work.

(c) Any nonexempt employee who elects to take time off under this Subsection (3) shall be paid for any overtime worked in excess of the cap established by the Department of Human Resource Management.

(d) Before working any overtime, each nonexempt employee shall obtain authorization to work overtime from the employee's immediate supervisor.

(e) Each department shall:

(i) for employees who elect to be compensated with time off for overtime, allow overtime earned during a fiscal year to be accumulated; and

(ii) for employees who elect to be paid for overtime worked, pay them for overtime worked in the paycheck for the pay period in which the employee worked the overtime.

(f) If the department pays a nonexempt employee for overtime, the department shall charge that payment to the department's budget.

(g) At the end of each fiscal year, the Division of Finance shall total all the accrued overtime hours for nonexempt employees and charge that total against the appropriate fund or subfund.

(4) (a) (i) Except as provided in Subsection (4)(a)(ii), each department shall compensate exempt employees who work overtime by granting them time off at the rate of one hour off for each hour of overtime worked.

(ii) The executive director of the Department of Human Resource Management may grant limited exceptions to this requirement, where work circumstances dictate, by authorizing a department to pay employees for overtime worked at the rate per hour that the employee

receives for nonovertime work, if the department has funds available.

(b) (i) Each department shall:

(A) establish in its written human resource policies a uniform annual date for each division that is at the end of any pay period; and

(B) communicate the uniform annual date to its employees.

(ii) If any department fails to establish a uniform annual date as required by this Subsection (4), the executive director of the Department of Human Resource Management, in conjunction with the director of the Division of Finance, shall establish the date for that department.

(c) (i) Any overtime earned under this Subsection (4) is not an entitlement, is not a benefit, and is not a vested right.

(ii) A court may not construe the overtime for exempt employees authorized by this Subsection (4) as an entitlement, a benefit, or as a vested right.

(d) At the end of the overtime year, upon transfer to another department at any time, and upon termination, retirement, or other situations where the employee will not return to work before the end of the overtime year:

(i) any of an exempt employee's overtime that is more than the maximum established by the Department of Human Resource Management rule lapses; and

(ii) unless authorized by the executive director of the Department of Human Resource Management under Subsection (4)(a)(ii), a department may not compensate the exempt employee for that lapsed overtime by paying the employee for the overtime or by granting the employee time off for the lapsed overtime.

(e) Before working any overtime, each exempt employee shall obtain authorization to work overtime from the exempt employee's immediate supervisor.

(f) If the department pays an exempt employee for overtime under authorization from the executive director of the Department of Human Resource Management, the department shall charge that payment to the department's budget in the pay period earned.

(5) The Department of Human Resource Management shall:

(a) ensure that the provisions of the FLSA and this section are implemented throughout state government;

(b) determine, for each state employee, whether that employee is exempt, nonexempt,

law enforcement, or has some other status under the FLSA;

(c) in coordination with modifications to the systems operated by the Division of Finance, make rules:

(i) establishing procedures for recording overtime worked that comply with FLSA requirements;

(ii) establishing requirements governing overtime worked while traveling and procedures for recording that overtime that comply with FLSA requirements;

(iii) establishing requirements governing overtime worked if the employee is "on call" and procedures for recording that overtime that comply with FLSA requirements;

(iv) establishing requirements governing overtime worked while an employee is being trained and procedures for recording that overtime that comply with FLSA requirements;

(v) subject to the FLSA, establishing the maximum number of hours that a nonexempt employee may accrue before a department is required to pay the employee for the overtime worked;

(vi) subject to the FLSA, establishing the maximum number of overtime hours for an exempt employee that do not lapse; and

(vii) establishing procedures for adjudicating appeals of any FLSA determinations made by the Department of Human Resource Management as required by this section;

(d) monitor departments for compliance with the FLSA; and

(e) recommend to the Legislature and the governor any statutory changes necessary because of federal government action.

(6) In coordination with the procedures for recording overtime worked established in rule by the Department of Human Resource Management, the Division of Finance shall modify its payroll and human resource systems to accommodate those procedures.

(a) Notwithstanding the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act, Section 67-19-31, and Section 67-19a-301, any employee who is aggrieved by the FLSA designation made by the Department of Human Resource Management as required by this section may appeal that determination to the executive director of the Department of Human Resource Management by following the procedures and requirements established in Department of Human Resource Management rule.

(b) Upon receipt of an appeal under this section, the executive director shall notify the

executive director of the employee's department that the appeal has been filed.

(c) If the employee is aggrieved by the decision of the executive director of the Department of Human Resource Management, the employee shall appeal that determination to the Department of Labor, Wage and Hour Division, according to the procedures and requirements of federal law.

Section 42. Section **67-19c-101** is amended to read:

67-19c-101. Department award program.

(1) As used in this section:

(a) "Department" means the Department of Administrative Services, the Department of Agriculture and Food, the Department of Alcoholic Beverage Control, the Department of Commerce, the Department of Community and Culture, the Department of Corrections, the Department of Workforce Services, the Department of Environmental Quality, the Department of Financial Institutions, the Department of Health, the Department of Human Resource Management, the Department of Human Services, [~~the Insurance Department,~~] the National Guard, the Department of Natural Resources, the Department of Public Safety, the Public Service Commission, the Labor Commission, the State Board of Education, the State Board of Regents, the State Tax Commission, the Department of Technology Services, and the Department of Transportation.

(b) "Department head" means the individual or body of individuals in whom the ultimate legal authority of the department is vested by law.

(2) There is created a department awards program to award an outstanding employee in each department of state government.

(3) (a) By April 1 of each year, each department head shall solicit nominations for outstanding employee of the year for [~~his~~] the department head's department from the employees in his department.

(b) By July 1 of each year, the department head shall:

(i) select a person from the department to receive the outstanding employee of the year award using the criteria established in Subsection (3)(c); and

(ii) announce the recipient of the award to [~~his~~] the department head's employees.

(c) Department heads shall make the award to a person who demonstrates:

(i) extraordinary competence in performing [~~his~~] the person's function;

(ii) creativity in identifying problems and devising workable, cost-effective solutions to them;

(iii) excellent relationships with the public and other employees;

(iv) a commitment to serving the public as the client; and

(v) a commitment to economy and efficiency in government.

(4) (a) The Department of Human Resource Management shall divide any appropriation for outstanding department employee awards that it receives from the Legislature equally among the departments.

(b) If the department receives money from the Department of Human Resource Management or if the department budget allows, the department head shall provide the employee with a bonus, a plaque, or some other suitable acknowledgement of the award.

(5) (a) The department head may name the award after an exemplary present or former employee of the department.

(b) A department head may not name the award for [~~himself~~] the department head or for any relative as defined in Section 52-3-1.

(c) Any awards or award programs existing in any department as of May 3, 1993, shall be modified to conform to the requirements of this section.

Section 43. Section **67-22-2** is amended to read:

67-22-2. Compensation -- Other state officers.

(1) As used in this section:

(a) "Appointed executive" means the:

(i) Commissioner of the Department of Agriculture and Food;

[~~(ii) Commissioner of the Insurance Department;~~]

[~~(iii)~~] (ii) Commissioner of the Labor Commission;

[~~(iv)~~] (iii) Director, Alcoholic Beverage Control Commission;

[~~(v)~~] (iv) Commissioner of the Department of Financial Institutions;

[~~(vi)~~] (v) Executive Director, Department of Commerce;

[~~(vii)~~] (vi) Executive Director, Commission on Criminal and Juvenile Justice;

[~~(viii)~~] (vii) Adjutant General;

[~~(ix)~~] (viii) Executive Director, Department of Community and Culture;

[~~(x)~~] (ix) Executive Director, Department of Corrections;

[~~(xi)~~] (x) Commissioner, Department of Public Safety;

[~~(xii)~~] (xi) Executive Director, Department of Natural Resources;

[~~(xiii)~~] (xii) Director, Governor's Office of Planning and Budget;

[~~(xiv)~~] (xiii) Executive Director, Department of Administrative Services;

[~~(xv)~~] (xiv) Executive Director, Department of Human Resource Management;

[~~(xvi)~~] (xv) Executive Director, Department of Environmental Quality;

[~~(xvii)~~] (xvi) Director, Governor's Office of Economic Development;

[~~(xviii)~~] (xvii) Executive Director, Utah Science Technology and Research Governing Authority;

[~~(xix)~~] (xviii) Executive Director, Department of Workforce Services;

[~~(xx)~~] (xix) Executive Director, Department of Health, Nonphysician;

[~~(xxi)~~] (xx) Executive Director, Department of Human Services;

[~~(xxii)~~] (xxi) Executive Director, Department of Transportation;

[~~(xxiii)~~] (xxii) Executive Director, Department of Technology Services; and

[~~(xxiv)~~] (xxiii) Executive Director, Department of Veterans Affairs.

(b) "Board or commission executive" means:

(i) Members, Board of Pardons and Parole;

(ii) Chair, State Tax Commission;

(iii) Commissioners, State Tax Commission;

(iv) Executive Director, State Tax Commission;

(v) Chair, Public Service Commission; and

(vi) Commissioners, Public Service Commission.

(c) "Deputy" means the person who acts as the appointed executive's second in command as determined by the Department of Human Resource Management.

(2) (a) The executive director of the Department of Human Resource Management shall:

(i) before October 31 of each year, recommend to the governor a compensation plan for the appointed executives and the board or commission executives; and

(ii) base those recommendations on market salary studies conducted by the Department of Human Resource Management.

(b) (i) The Department of Human Resource Management shall determine the salary

range for the appointed executives by:

(A) identifying the salary range assigned to the appointed executive's deputy;

(B) designating the lowest minimum salary from those deputies' salary ranges as the minimum salary for the appointed executives' salary range; and

(C) designating 105% of the highest maximum salary range from those deputies' salary ranges as the maximum salary for the appointed executives' salary range.

(ii) If the deputy is a medical doctor, the Department of Human Resource Management may not consider that deputy's salary range in designating the salary range for appointed executives.

(c) In establishing the salary ranges for board or commission executives, the Department of Human Resource Management shall set the maximum salary in the salary range for each of those positions at 90% of the salary for district judges as established in the annual appropriation act under Section 67-8-2.

(3) (a) (i) Except as provided in Subsection (3)(a)(ii), the governor shall establish a specific salary for each appointed executive within the range established under Subsection (2)(b).

(ii) If the executive director of the Department of Health is a physician, the governor shall establish a salary within the highest physician salary range established by the Department of Human Resource Management.

(iii) The governor may provide salary increases for appointed executives within the range established by Subsection (2)(b) and identified in Subsection (3)(a)(ii).

(b) The governor shall apply the same overtime regulations applicable to other FLSA exempt positions.

(c) The governor may develop standards and criteria for reviewing the appointed executives.

(4) Salaries for other Schedule A employees, as defined in Section 67-19-15, that are not provided for in this chapter, or in Title 67, Chapter 8, Utah Elected Official and Judicial Salary Act, shall be established as provided in Section 67-19-15.

(5) (a) The Legislature fixes benefits for the appointed executives and the board or commission executives as follows:

(i) the option of participating in a state retirement system established by Title 49, Utah

State Retirement and Insurance Benefit Act, or in a deferred compensation plan administered by the State Retirement Office in accordance with the Internal Revenue Code and its accompanying rules and regulations;

(ii) health insurance;

(iii) dental insurance;

(iv) basic life insurance;

(v) unemployment compensation;

(vi) workers' compensation;

(vii) required employer contribution to Social Security;

(viii) long-term disability income insurance;

(ix) the same additional state-paid life insurance available to other noncareer service employees;

(x) the same severance pay available to other noncareer service employees;

(xi) the same leave, holidays, and allowances granted to Schedule B state employees as follows:

(A) sick leave;

(B) converted sick leave if accrued prior to January 1, 2014;

(C) educational allowances;

(D) holidays; and

(E) annual leave except that annual leave shall be accrued at the maximum rate provided to Schedule B state employees;

(xii) the option to convert accumulated sick leave to cash or insurance benefits as provided by law or rule upon resignation or retirement according to the same criteria and procedures applied to Schedule B state employees;

(xiii) the option to purchase additional life insurance at group insurance rates according to the same criteria and procedures applied to Schedule B state employees; and

(xiv) professional memberships if being a member of the professional organization is a requirement of the position.

(b) Each department shall pay the cost of additional state-paid life insurance for its executive director from its existing budget.

(6) The Legislature fixes the following additional benefits:

(a) for the executive director of the State Tax Commission a vehicle for official and personal use;

(b) for the executive director of the Department of Transportation a vehicle for official and personal use;

(c) for the executive director of the Department of Natural Resources a vehicle for commute and official use;

(d) for the Commissioner of Public Safety:

(i) an accidental death insurance policy if POST certified; and

(ii) a public safety vehicle for official and personal use;

(e) for the executive director of the Department of Corrections:

(i) an accidental death insurance policy if POST certified; and

(ii) a public safety vehicle for official and personal use;

(f) for the Adjutant General a vehicle for official and personal use; and

(g) for each member of the Board of Pardons and Parole a vehicle for commute and official use.

Section 44. Section **70C-6-105** is amended to read:

70C-6-105. Maximum charge by creditor for insurance.

If a creditor contracts for or receives a separate charge for insurance, the amount charged the debtor for the insurance may not exceed the premium to be charged by the insurer, without deduction for commissions, as computed at the time the charge to the debtor is determined, conforming to any rate filings required by law and made by the insurer with the [~~commissioner of insurance~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance.

Section 45. Section **70C-6-106** is amended to read:

70C-6-106. Refund or credit required -- Amount.

(1) A debtor or [~~his~~] the debtor's estate is entitled to any rebate or refund due from an insurer and to any unearned part of a separate charge for insurance previously paid by the debtor, resulting from the prepayment of a consumer credit debt, except when all refunds and credits due to the debtor under this title amount to less than $5.

(2) A creditor shall promptly make or cause to be made an appropriate refund or credit to the debtor with respect to any separate charge made to him for insurance if:

(a) the insurance is not provided or is provided for a shorter term than that for which the charge to a debtor for insurance was computed; or

(b) the insurance terminates prior to the end of the term for which it was written because of prepayment in full or otherwise.

(3) All refunds or credit required by this section shall be computed according to a method prescribed or approved by the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, or formula filed by the insurer with the [~~Insurance Department~~] Department of Commerce at least 30 days before any debtor's right to a refund or credit becomes determinable, unless the method or formula is employed after the [~~Insurance Department~~] Department of Commerce notifies the insurer that the method or formula has been disapproved.

(4) Except as provided in Subsection (1), a creditor is not obligated to account to a debtor for any portion of a separate charge for insurance when:

(a) the insurance is terminated by performance of the insurer's obligation;

(b) the creditor pays or accounts for premiums to the insurer in amounts and at times determined by the agreement between them; or

(c) the creditor receives directly or indirectly under any policy of insurance a gain or advantage not prohibited by law.

Section 46. Section **70C-6-203** is amended to read:

70C-6-203. Filing and approval of rates and forms.

(1) A creditor may use a form or a schedule of premium rates or charges concerning consumer credit insurance only if the form or schedule has been on file with the [~~Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, for at least 30 days and has not been disapproved by the [~~Insurance Department~~] Department of Commerce or has been specifically approved by the [~~Insurance Department~~] Department of Commerce at any time after filing.

(2) Except as provided in Subsection (3), all policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders relating to consumer credit insurance delivered or issued for delivery in this state, and the schedules of premium rates or charges pertaining to them, shall be filed by the insurer with the [~~Insurance Department~~] Department of Commerce. Within 30 days after the filing of any form or

schedule, the [~~Insurance Department~~] Department of Commerce shall disapprove it if the premium rates or charges are unreasonable in relation to the benefits provided under the form, or if the form contains provisions which are unjust, unfair, inequitable, or deceptive, or encourages misrepresentation, or are contrary to any provisions of this title, or Title 31A, Chapter 22, Part 8, Credit Life and Accident and Health Insurance, or of any rule adopted under that act or this title.

(3) If a group policy has been delivered in another state, the forms to be filed by the insurer with the [~~Insurance Department~~] Department of Commerce are the group certificates and notices of proposed insurance. The [~~Insurance Department~~] Department of Commerce shall approve those certificates and notices if:

(a) they provide the information that would be required if the group policy were delivered in this state; and

(b) the applicable premium rates or charges do not exceed those established by the [~~Insurance Department's~~] rules of the Department of Commerce under Title 31A, Insurance Code.

Section 47. Section **72-6-107.5** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

(c) "Qualified health insurance coverage" means at the time the contract is entered into or renewed:

(i) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and a contribution level of 50% of the premium for the employee and the dependents of the

employee who reside or work in the state, in which:

(A) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(Aa) the deductible is $750 per individual and $2,250 per family; and

(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a deductible that is either:

(I) the lowest deductible permitted for a federally qualified high deductible health plan; or

(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(B) an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.

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

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

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

(ii) A subcontractor is subject to this section if a subcontract is in the amount of

$750,000 or greater.

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the department compliance with this section which shall include:

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

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

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

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

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

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

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of the employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the benchmark for the qualified

health insurance coverage identified in Subsection (1)(c)(i).

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

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

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

(I) an actuary; or

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

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

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

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

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

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

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

Section 48. Section **76-6-521** is amended to read:

76-6-521. Fraudulent insurance act.

(1) A person commits a fraudulent insurance act if that person with intent to defraud:

(a) presents or causes to be presented any oral or written statement or representation knowing that the statement or representation contains false or fraudulent information

concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract;

(b) presents, or causes to be presented, any oral or written statement or representation:

(i) (A) as part of or in support of a claim for payment or other benefit pursuant to an insurance policy, certificate, or contract; or

(B) in connection with any civil claim asserted for recovery of damages for personal or bodily injuries or property damage; and

(ii) knowing that the statement or representation contains false or fraudulent information concerning any fact or thing material to the claim;

(c) knowingly accepts a benefit from proceeds derived from a fraudulent insurance act;

(d) intentionally, knowingly, or recklessly devises a scheme or artifice to obtain fees for professional services, or anything of value by means of false or fraudulent pretenses, representations, promises, or material omissions;

(e) knowingly employs, uses, or acts as a runner, as defined in Section 31A-31-102, for the purpose of committing a fraudulent insurance act;

(f) knowingly assists, abets, solicits, or conspires with another to commit a fraudulent insurance act; or

(g) knowingly supplies false or fraudulent material information in any document or statement required by the [~~Department of Insurance~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance.

(2) (a) A violation of Subsection (1)(a) is a class B misdemeanor.

(b) A violation of Subsections (1)(b) through (1)(g) is punishable as in the manner prescribed by Section 76-10-1801 for communication fraud for property of like value.

(3) A corporation or association is guilty of the offense of insurance fraud under the same conditions as those set forth in Section 76-2-204.

(4) The determination of the degree of any offense under Subsections (1)(b) through (1)(g) shall be measured by the total value of all property, money, or other things obtained or sought to be obtained by the fraudulent insurance act or acts described in Subsections (1)(b) through (1)(g).

Section 49. Section **76-10-915** is amended to read:

76-10-915. Exempt activities.

(1) This act may not be construed to prohibit:

(a) the activities of any public utility to the extent that those activities are subject to regulation by the public service commission, the state or federal department of transportation, the federal energy regulatory commission, the federal communications commission, the interstate commerce commission, or successor agencies;

(b) the activities of any insurer, insurance producer, independent insurance adjuster, or rating organization including, but not limited to, making or participating in joint underwriting or reinsurance arrangements, to the extent that those activities are subject to regulation by the [~~commissioner of insurance~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

(c) the activities of securities dealers, issuers, or agents, to the extent that those activities are subject to regulation under the laws of either this state or the United States;

(d) the activities of any state or national banking institution, to the extent that the activities are regulated or supervised by state government officers or agencies under the banking laws of this state or by federal government officers or agencies under the banking laws of the United States;

(e) the activities of any state or federal savings and loan association to the extent that those activities are regulated or supervised by state government officers or agencies under the banking laws of this state or federal government officers or agencies under the banking laws of the United States;

(f) the activities of a political subdivision to the extent authorized or directed by state law, consistent with the state action doctrine of federal antitrust law; or

(g) the activities of an emergency medical service provider licensed under Title 26, Chapter 8a, Utah Emergency Medical Services System Act, to the extent that those activities are regulated by state government officers or agencies under that act.

(2) (a) The labor of a human being is not a commodity or article of commerce.

(b) Nothing contained in the antitrust laws shall be construed to forbid the existence and operation of labor, agricultural, or horticultural organizations, instituted for the purpose of mutual help and not having capital stock or conducted for profit, or to forbid or restrain individual members of these organizations from lawfully carrying out their legitimate objects; nor may these organizations or membership in them be held to be illegal combinations or

conspiracies in restraint of trade under the antitrust laws.

(3) (a) As used in this section, an entity is also a municipality if the entity was formed under Title 11, Chapter 13, Interlocal Cooperation Act, prior to January 1, 1981, and the entity is:

(i) a project entity as defined in Section 11-13-103;

(ii) an electric interlocal entity as defined in Section 11-13-103; or

(iii) an energy services interlocal entity as defined in Section 11-13-103.

(b) The activities of the entities under Subsection (3)(a) are authorized or directed by state law.

Section 50. Section **77-20-5** is amended to read:

77-20-5. Qualifications of sureties -- Justification -- Requirements of undertaking.

(1) The sureties on written undertakings shall be real or personal property holders within the state. The qualifications and bonding limits of bail bond sureties who are engaged in the for-profit, commercial business of posting property bonds shall be established by the Bail Bond Surety Oversight Board and rules adopted by the [~~insurance commissioner~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance. All other sureties shall collectively have a net worth of at least twice the amount of the undertaking, exclusive of property exempt from execution.

(2) Each surety shall justify by affidavit upon the undertaking and each may be further examined upon oath by the magistrate or by the prosecuting attorney in the presence of a magistrate, in respect to [~~his~~] the surety's property and net worth.

(3) The undertaking shall, in addition to other requirements, provide that each surety submits [~~himself~~] the surety to the jurisdiction of the court and irrevocably appoints the clerk of the court as [~~his~~] the surety's agent upon whom any papers affecting [~~his~~] the surety's liability on the undertaking may be served, and that [~~his~~] the surety's liability may be enforced on motion and upon such notice as the court may require without the necessity of an independent action.

Section 51. Section **78B-3-403** is amended to read:

78B-3-403. Definitions.

As used in this part:

(1) "Audiologist" means a person licensed to practice audiology under Title 58, Chapter 41, Speech-language Pathology and Audiology Licensing Act.

(2) "Certified social worker" means a person licensed to practice as a certified social worker under Section 58-60-205.

(3) "Chiropractic physician" means a person licensed to practice chiropractic under Title 58, Chapter 73, Chiropractic Physician Practice Act.

(4) "Clinical social worker" means a person licensed to practice as a clinical social worker under Section 58-60-205.

(5) "Commissioner" means the [~~commissioner of insurance as provided in Section 31A-2-102~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance.

(6) "Dental hygienist" means a person licensed to engage in the practice of dental hygiene as defined in Section 58-69-102.

(7) "Dentist" means a person licensed to engage in the practice of dentistry as defined in Section 58-69-102.

(8) "Division" means the Division of Occupational and Professional Licensing created in Section 58-1-103.

(9) "Future damages" includes a judgment creditor's damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering.

(10) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(11) "Health care facility" means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, health care facilities owned or operated by health maintenance organizations, and end stage renal disease facilities.

(12) "Health care provider" includes any person, partnership, association, corporation, or other facility or institution who causes to be rendered or who renders health care or professional services as a hospital, health care facility, physician, registered nurse, licensed practical nurse, nurse-midwife, licensed Direct-entry midwife, dentist, dental hygienist,

optometrist, clinical laboratory technologist, pharmacist, physical therapist, physical therapist assistant, podiatric physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist, speech-language pathologist, clinical social worker, certified social worker, social service worker, marriage and family counselor, practitioner of obstetrics, or others rendering similar care and services relating to or arising out of the health needs of persons or groups of persons and officers, employees, or agents of any of the above acting in the course and scope of their employment.

(13) "Hospital" means a public or private institution licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(14) "Licensed Direct-entry midwife" means a person licensed under the Direct-entry Midwife Act to engage in the practice of direct-entry midwifery as defined in Section 58-77-102.

(15) "Licensed practical nurse" means a person licensed to practice as a licensed practical nurse as provided in Section 58-31b-301.

(16) "Malpractice action against a health care provider" means any action against a health care provider, whether in contract, tort, breach of warranty, wrongful death, or otherwise, based upon alleged personal injuries relating to or arising out of health care rendered or which should have been rendered by the health care provider.

(17) "Marriage and family therapist" means a person licensed to practice as a marriage therapist or family therapist under Sections 58-60-305 and 58-60-405.

(18) "Naturopathic physician" means a person licensed to engage in the practice of naturopathic medicine as defined in Section 58-71-102.

(19) "Nurse-midwife" means a person licensed to engage in practice as a nurse midwife under Section 58-44a-301.

(20) "Optometrist" means a person licensed to practice optometry under Title 58, Chapter 16a, Utah Optometry Practice Act.

(21) "Osteopathic physician" means a person licensed to practice osteopathy under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(22) "Patient" means a person who is under the care of a health care provider, under a contract, express or implied.

(23) "Periodic payments" means the payment of money or delivery of other property to

a judgment creditor at intervals ordered by the court.

(24) "Pharmacist" means a person licensed to practice pharmacy as provided in Section 58-17b-301.

(25) "Physical therapist" means a person licensed to practice physical therapy under Title 58, Chapter 24b, Physical Therapy Practice Act.

(26) "Physical therapist assistant" means a person licensed to practice physical therapy, within the scope of a physical therapist assistant license, under Title 58, Chapter 24b, Physical Therapy Practice Act.

(27) "Physician" means a person licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act.

(28) "Podiatric physician" means a person licensed to practice podiatry under Title 58, Chapter 5a, Podiatric Physician Licensing Act.

(29) "Practitioner of obstetrics" means a person licensed to practice as a physician in this state under Title 58, Chapter 67, Utah Medical Practice Act, or under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(30) "Psychologist" means a person licensed under Title 58, Chapter 61, Psychologist Licensing Act, to engage in the practice of psychology as defined in Section 58-61-102.

(31) "Registered nurse" means a person licensed to practice professional nursing as provided in Section 58-31b-301.

(32) "Relative" means a patient's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister, or spouse's parents. The term includes relationships that are created as a result of adoption.

(33) "Representative" means the spouse, parent, guardian, trustee, attorney-in-fact, person designated to make decisions on behalf of a patient under a medical power of attorney, or other legal agent of the patient.

(34) "Social service worker" means a person licensed to practice as a social service worker under Section 58-60-205.

(35) "Speech-language pathologist" means a person licensed to practice speech-language pathology under Title 58, Chapter 41, Speech-language Pathology and Audiology Licensing Act.

(36) "Tort" means any legal wrong, breach of duty, or negligent or unlawful act or

omission proximately causing injury or damage to another.

(37) "Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected result.

Section 52. Section **78B-3-413** is amended to read:

78B-3-413. Professional liability insurance coverage for providers -- Joint underwriting authority.

(1) The [~~commissioner~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance, may, after a public hearing, find that professional liability insurance coverage for health care providers is not readily available in the voluntary market in a specific part of this state, and that the public interest requires that action be taken.

(2) The [~~commissioner~~] Department of Commerce may promulgate rules and implement plans to provide insurance coverage through all insurers issuing professional liability policies and individual and group accident and sickness policies providing medical, surgical or hospital expense coverage on either a prepaid or an expense incurred basis, including personal injury protection and medical expense coverage issued incidental to liability insurance policies.

Section 53. Section **79-2-404** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

(c) "Qualified health insurance coverage" means at the time the contract is entered into or renewed:

(i) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and

a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(A) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):

(I) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(Aa) the deductible is $750 per individual and $2,250 per family; and

(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(II) dental coverage is not required; and

(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a deductible that is either:

(I) the lowest deductible permitted for a federally qualified high deductible health plan; or

(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(B) an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.

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

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

(b) (i) A prime contractor is subject to this section if the prime contract is in the

amount of $1,500,000 or greater.

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

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

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

(b) the contract or agreement is between:

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

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

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

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

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during

the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate compliance with this section to the department which shall include:

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

(B) that the actuarially equivalent determination required in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the [~~Utah Insurance Department~~] Department of Commerce under Title 31A, Insurance Code, which may delegate this function to the Division of Insurance;

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

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

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

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

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

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

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

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

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

(I) an actuary; or

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

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

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

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

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

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

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

Section 54. **Repealer.**

This bill repeals:

Section **31A-2-102, Appointment, general powers, and duties of commissioner -- Vacancy -- Compensation of commissioner.**

Section **31A-2-103, Commissioner's appointees.**

Section **31A-2-105, Constitutional oath.**

Section 55. **Effective date.**

Section 31A-2a-103, enacted in this bill, takes effect on May 10, 2011, the remainder of the bill takes effect on July 1, 2011.

Section 56. **Revisor instructions.**

It is the intent of the Legislature that, in preparing the Utah Code database for publication, the Office of Legislative Research and General Counsel shall replace the reference in Section 31A-2a-103 from "this bill" to the bill's designated chapter and section number in the Laws of Utah.

Legislative Review Note
as of 2-11-11 3:47 PM

Office of Legislative Research and General Counsel