

1 **HEALTH REFORM AMENDMENTS**

2 2011 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: John L. Valentine

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7 **LONG TITLE**

8 **General Description:**

9 This bill amends provisions related to state health system reform in the Health Code,  
10 the Insurance Code, and the Governor's Programs.

11 **Highlighted Provisions:**

12 This bill:

- 13 ▶ amends the definition of third party payor in the Utah Health Data Authority Act;
- 14 ▶ requires the Health Data Authority to publish comparative data about physician and  
15 clinic quality by October 1, 2011;
- 16 ▶ amends the membership of the Health Data Authority;
- 17 ▶ clarifies duties between the Department of Health, the Department of Insurance, and  
18 the Office of Consumer Health Services related to:
  - 19 • convening and supervising the health delivery and payment reform  
20 demonstration projects; and
  - 21 • regulation of insurers in the Health Insurance Exchange;
- 22 ▶ clarifies the dental coverage for the Children's Health Insurance Program;
- 23 ▶ amends the definition of qualified health plan that a state contractor shall offer to  
24 employees;
- 25 ▶ establishes state authority to regulate certain practices of health insurers;
- 26 ▶ requires group health benefit plans to have reasonable plan premium rates and to  
27 comply with standards established by the Insurance Department;
- 28 ▶ amends small group mental health offering;
- 29 ▶ amends provisions related to Utah NetCare;

- 30           ▶ amends provisions related to the basic health care plan;
- 31           ▶ prohibits an insurance customer representative from practicing independent of a
- 32 producer or consultant employer, and limits a customer service representative's
- 33 authority to bind coverage;
- 34           ▶ amends small group case characteristics and allows premiums to vary based on
- 35 gender;
- 36           ▶ gives the Insurance Department the responsibility to conduct an actuarial review of
- 37 rates established for the health benefit plan market;
- 38           ▶ authorizes the department to establish a fee for the actuarial review;
- 39           ▶ amends provisions related to the appointment of brokers to the Health Insurance
- 40 Exchange;
- 41           ▶ removes language from the Risk Adjuster Board chapter of the Insurance Code
- 42 related to the actuarial review of rates;
- 43           ▶ establishes the money in the Health Insurance Actuarial Review Restricted Account
- 44 as non-lapsing;
- 45           ▶ removes the large group market from the Health Insurance Exchange;
- 46           ▶ clarifies the authority of the Office of Consumer Health Services to:
- 47           • contract with private entities for the purpose of administering functions of the
- 48 Health Insurance Exchange;
- 49           • establish a call center for customer service in the exchange; and
- 50           • charge a fee for certain functions of the exchange;
- 51           ▶ moves language regarding insurance regulation from the Office of Consumer Health
- 52 Services to the Insurance Code;
- 53           ▶ reauthorizes the Health System Reform Task Force, including:
- 54           • membership of the task force; and
- 55           • duties of the task force;
- 56           ▶ creates the Health Insurance Actuarial Review Restricted Account;
- 57           ▶ provides intent language that fees received by the Insurance Department in 2010, for

58 the department's actuarial review as dedicated credits, shall lapse to the Health Insurance  
59 Actuarial Review Restricted Account;  
60       ▶ repeals the statewide risk adjuster mechanism that was effective January 1, 2013;  
61 and  
62       ▶ makes technical and conforming amendments.

63 **Money Appropriated in this Bill:**

64       None

65 **Other Special Clauses:**

66       This bill provides a repeal date for certain provisions.

67 **Utah Code Sections Affected:**

68 AMENDS:

- 69       **17B-2a-818.5**, as last amended by Laws of Utah 2010, Chapter 229
- 70       **19-1-206**, as last amended by Laws of Utah 2010, Chapters 218 and 229
- 71       **26-33a-102**, as last amended by Laws of Utah 1996, Chapter 232
- 72       **26-33a-103**, as last amended by Laws of Utah 2010, Chapter 286
- 73       **26-33a-106.5**, as last amended by Laws of Utah 2005, Chapter 266
- 74       **26-40-106**, as last amended by Laws of Utah 2007, Chapter 47
- 75       **31A-2-212**, as last amended by Laws of Utah 2007, Chapter 309
- 76       **31A-22-613.5**, as last amended by Laws of Utah 2010, Chapters 68, 149 and last  
77 amended by Coordination Clause, Laws of Utah 2010, Chapter 149
- 78       **31A-22-614.6**, as last amended by Laws of Utah 2010, Chapter 68
- 79       **31A-22-625**, as last amended by Laws of Utah 2010, Chapters 10 and 68
- 80       **31A-22-635**, as last amended by Laws of Utah 2010, Chapter 68
- 81       **31A-22-724**, as enacted by Laws of Utah 2009, Chapter 12
- 82       **31A-29-103**, as last amended by Laws of Utah 2008, Chapters 3 and 385
- 83       **31A-30-103**, as last amended by Laws of Utah 2010, Chapter 68
- 84       **31A-30-104**, as last amended by Laws of Utah 2009, Chapter 12
- 85       **31A-30-106.1**, as enacted by Laws of Utah 2010, Chapter 68

- 86           **31A-30-203**, as last amended by Laws of Utah 2010, Chapter 68
- 87           **31A-30-205**, as last amended by Laws of Utah 2010, Chapters 68, 149 and last
- 88 amended by Coordination Clause, Laws of Utah 2010, Chapter 149
- 89           **31A-30-207**, as last amended by Laws of Utah 2010, Chapter 68
- 90           **31A-30-208**, as repealed and reenacted by Laws of Utah 2010, Chapter 68
- 91           **31A-30-209**, as enacted by Laws of Utah 2010, Chapter 68
- 92           **31A-42-202**, as last amended by Laws of Utah 2010, Chapter 68
- 93           **63A-5-205**, as last amended by Laws of Utah 2010, Chapter 229
- 94           **63C-9-403**, as last amended by Laws of Utah 2010, Chapter 229
- 95           **63I-1-231**, as last amended by Laws of Utah 2010, Chapters 68 and 319
- 96           **63J-1-602.2**, as enacted by Laws of Utah 2010, Chapter 265 and last amended by
- 97 Coordination Clause, Laws of Utah 2010, Chapter 265
- 98           **63M-1-2504**, as last amended by Laws of Utah 2010, Chapter 68
- 99           **63M-1-2506**, as last amended by Laws of Utah 2010, Chapter 68
- 100          **72-6-107.5**, as last amended by Laws of Utah 2010, Chapter 229
- 101          **79-2-404**, as last amended by Laws of Utah 2010, Chapter 229

102 ENACTS:

- 103          **26-1-39**, Utah Code Annotated 1953
- 104          **26-40-115**, Utah Code Annotated 1953
- 105          **31A-23a-115.5**, Utah Code Annotated 1953
- 106          **31A-30-115**, Utah Code Annotated 1953
- 107          **31A-30-211**, Utah Code Annotated 1953

108 REPEALS:

- 109          **31A-42a-101 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
- 110          **31A-42a-102 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
- 111          **31A-42a-201 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
- 112          **31A-42a-202 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
- 113          **31A-42a-203 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68

114 31A-42a-204 (Effective 01/01/13), as enacted by Laws of Utah 2010, Chapter 68

115 **Uncodified Material Affected:**

116 ENACTS UNCODIFIED MATERIAL

117 REPEALS UNCODIFIED MATERIAL:

118 **Laws of Utah 2010, Chapter 68, Uncodified Section 48**

119 **Laws of Utah 2010, Chapter 68, Uncodified Section 49**

120 **Laws of Utah 2010, Chapter 68, Uncodified Section 50, Subsection (3)**

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

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

124 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**  
125 **coverage.**

126 (1) For purposes of this section:

127 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
128 34A-2-104 who:

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

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

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

133 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~  
134 ~~or renewed;~~] is as defined in Section 26-40-115.

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

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

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

143 ~~[(F) rather that the benchmark plan's deductible, and the benchmark plan's~~

144 ~~out-of-pocket maximum based on income levels:]~~

145 ~~[(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

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

147 ~~[(H) dental coverage is not required; and]~~

148 ~~[(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~

149 ~~not apply; or]~~

150 ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~

151 ~~deductible that is either:]~~

152 ~~[(F) the lowest deductible permitted for a federally qualified high deductible health~~

153 ~~plan; or]~~

154 ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~

155 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~

156 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~

157 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~

158 ~~employer offered federally qualified high deductible plan;]~~

159 ~~[(B) an out-of-pocket maximum that does not exceed three times the amount of the~~

160 ~~annual deductible; and]~~

161 ~~[(C) under which the employer pays 75% of the premium for the employee and the~~

162 ~~dependents of the employee who work or reside in the state:]~~

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

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

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

169 (ii) A subcontractor is subject to this section if a subcontract is in the amount of

170 \$750,000 or greater.

171 (3) This section does not apply if:

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

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

174 (c) the contract is an emergency procurement.

175 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]

176 63G-6-103, or a modification to a contract, when the contract does not meet the initial

177 threshold required by Subsection (2).

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

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

180 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit

181 district that the contractor has and will maintain an offer of qualified health insurance coverage

182 for the contractor's employees and the employee's dependents during the duration of the

183 contract.

184 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor

185 shall demonstrate to the public transit district that the subcontractor has and will maintain an

186 offer of qualified health insurance coverage for the subcontractor's employees and the

187 employee's dependents during the duration of the contract.

188 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during

189 the duration of the contract is subject to penalties in accordance with an ordinance adopted by

190 the public transit district under Subsection (6).

191 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the

192 requirements of Subsection (5)(b).

193 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during

194 the duration of the contract is subject to penalties in accordance with an ordinance adopted by

195 the public transit district under Subsection (6).

196 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the

197 requirements of Subsection (5)(a).

- 198 (6) The public transit district shall adopt ordinances:  
199 (a) in coordination with:  
200 (i) the Department of Environmental Quality in accordance with Section 19-1-206;  
201 (ii) the Department of Natural Resources in accordance with Section 79-2-404;  
202 (iii) the State Building Board in accordance with Section 63A-5-205;  
203 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and  
204 (v) the Department of Transportation in accordance with Section 72-6-107.5; and  
205 (b) which establish:  
206 (i) the requirements and procedures a contractor must follow to demonstrate to the  
207 public transit district compliance with this section which shall include:  
208 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or  
209 (b) more than twice in any 12-month period; and  
210 (B) that the actuarially equivalent determination required for the qualified health  
211 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the  
212 department or division with a written statement of actuarial equivalency from either:  
213 (I) the Utah Insurance Department;  
214 (II) an actuary selected by the contractor or the contractor's insurer; or  
215 (III) an underwriter who is responsible for developing the employer group's premium  
216 rates;  
217 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
218 violates the provisions of this section, which may include:  
219 (A) a three-month suspension of the contractor or subcontractor from entering into  
220 future contracts with the public transit district upon the first violation;  
221 (B) a six-month suspension of the contractor or subcontractor from entering into future  
222 contracts with the public transit district upon the second violation;  
223 (C) an action for debarment of the contractor or subcontractor in accordance with  
224 Section 63G-6-804 upon the third or subsequent violation; and  
225 (D) monetary penalties which may not exceed 50% of the amount necessary to



226 purchase qualified health insurance coverage for employees and dependents of employees of  
227 the contractor or subcontractor who were not offered qualified health insurance coverage  
228 during the duration of the contract; and

229 (iii) a website on which the district shall post the benchmark for the qualified health  
230 insurance coverage identified in Subsection (1)(c)[(†)].

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

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

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

239 (I) actuary; or

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

241 or

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

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

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

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

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

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

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

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

257 **19-1-206. Contracting powers of department -- Health insurance coverage.**

258 (1) For purposes of this section:

259 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
260 34A-2-104 who:

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

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

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

265 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~  
266 ~~or renewed;~~] is as defined in Section 26-40-115.

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

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

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

275 [~~(f) rather than the benchmark plan's deductible, and the benchmark plan's~~  
276 ~~out-of-pocket maximum based on income levels;~~]

277 [~~(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

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

279 [~~(H) dental coverage is not required; and]~~

280 [~~(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~  
281 ~~not apply; or]~~

282           ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~  
283 ~~deductible that is either:]~~

284           ~~[(F) the lowest deductible permitted for a federally qualified high deductible health~~  
285 ~~plan; or]~~

286           ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~  
287 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~  
288 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~  
289 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~  
290 ~~employer offered federally qualified high deductible plan;]~~

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

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

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

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

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

302           (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
303 \$750,000 or greater.

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

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

307           (b) the contract or agreement is between:

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

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

- 310 (B) the federal government;
- 311 (C) another state;
- 312 (D) an interstate agency;
- 313 (E) a political subdivision of this state; or
- 314 (F) a political subdivision of another state;
- 315 (c) the executive director determines that applying the requirements of this section to a
- 316 particular contract interferes with the effective response to an immediate health and safety
- 317 threat from the environment; or
- 318 (d) the contract is:
  - 319 (i) a sole source contract; or
  - 320 (ii) an emergency procurement.
- 321 (4) (a) This section does not apply to a change order as defined in Section 63G-6-103,
- 322 or a modification to a contract, when the contract does not meet the initial threshold required
- 323 by Subsection (2).
- 324 (b) A person who intentionally uses change orders or contract modifications to
- 325 circumvent the requirements of Subsection (2) is guilty of an infraction.
- 326 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
- 327 director that the contractor has and will maintain an offer of qualified health insurance
- 328 coverage for the contractor's employees and the employees' dependents during the duration of
- 329 the contract.
- 330 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
- 331 demonstrate to the executive director that the subcontractor has and will maintain an offer of
- 332 qualified health insurance coverage for the subcontractor's employees and the employees'
- 333 dependents during the duration of the contract.
- 334 (c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration
- 335 of the contract is subject to penalties in accordance with administrative rules adopted by the
- 336 department under Subsection (6).
- 337 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the

338 requirements of Subsection (5)(b).

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

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

344 (6) The department shall adopt administrative rules:

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

346 (b) in coordination with:

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

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

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

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

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

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

353 (c) which establish:

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

356 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

357 (b) more than twice in any 12-month period; and

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

361 (I) the Utah Insurance Department;

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

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

365 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

366 violates the provisions of this section, which may include:

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

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

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

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

377 (iii) a website on which the department shall post the benchmark for the qualified  
378 health insurance coverage identified in Subsection (1)(c)[(†)].

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

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

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

387 (I) an actuary; or

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

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

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

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

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

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

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

404 Section 3. Section **26-1-39** is enacted to read:

405 **26-1-39. Health System Reform Demonstration Projects.**

406 The department may coordinate with the Insurance Department and periodically  
407 convene health care providers, payers, and consumers, who elect to participate in a  
408 demonstration project under Section 31A-22-614.6, to monitor the progress being made  
409 regarding demonstration projects for health care delivery and payment reform under Section  
410 31A-22-614.6.

411 Section 4. Section **26-33a-102** is amended to read:

412 **26-33a-102. Definitions.**

413 As used in this chapter:

414 (1) "Committee" means the Health Data Committee created by Section 26-1-7.

415 (2) "Control number" means a number assigned by the committee to an individual's  
416 health data as an identifier so that the health data can be disclosed or used in research and  
417 statistical analysis without readily identifying the individual.

418 (3) "Data supplier" means a health care facility, health care provider, self-funded  
419 employer, third-party payor, health maintenance organization, or government department which  
420 could reasonably be expected to provide health data under this chapter.

421 (4) "Disclosure" or "disclose" means the communication of health care data to any

422 individual or organization outside the committee, its staff, and contracting agencies.

423 (5) "Executive director" means the director of the department.

424 (6) "Health care facility" means a facility that is licensed by the department under Title  
425 26, Chapter 21, Health Care Facility [~~Licensure~~] Licensing and Inspection Act. The committee  
426 may by rule add, delete, or modify the list of facilities that come within this definition for  
427 purposes of this chapter.

428 (7) "Health care provider" means any person, partnership, association, corporation, or  
429 other facility or institution that renders or causes to be rendered health care or professional  
430 services as a physician, registered nurse, licensed practical nurse, nurse-midwife, dentist, dental  
431 hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, podiatric  
432 physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician,  
433 osteopathic physician and surgeon, audiologist, speech pathologist, certified social worker,  
434 social service worker, social service aide, marriage and family counselor, or practitioner of  
435 obstetrics, and others rendering similar care and services relating to or arising out of the health  
436 needs of persons or groups of persons, and officers, employees, or agents of any of the above  
437 acting in the course and scope of their employment.

438 (8) "Health data" means information relating to the health status of individuals, health  
439 services delivered, the availability of health manpower and facilities, and the use and costs of  
440 resources and services to the consumer, except vital records as defined in Section 26-2-2 shall  
441 be excluded.

442 (9) "Health maintenance organization" has the meaning set forth in Section 31A-8-101.

443 (10) "Identifiable health data" means any item, collection, or grouping of health data  
444 that makes the individual supplying or described in the health data identifiable.

445 (11) "Individual" means a natural person.

446 (12) "Organization" means any corporation, association, partnership, agency,  
447 department, unit, or other legally constituted institution or entity, or part thereof.

448 (13) "Research and statistical analysis" means activities using health data analysis  
449 including:



- 450 (a) describing the group characteristics of individuals or organizations;
- 451 (b) analyzing the noncompliance among the various characteristics of individuals or
- 452 organizations;
- 453 (c) conducting statistical procedures or studies to improve the quality of health data;
- 454 (d) designing sample surveys and selecting samples of individuals or organizations;
- 455 and
- 456 (e) preparing and publishing reports describing these matters.

457 (14) "Self-funded employer" means an employer who provides for the payment of  
 458 health care services for [his] employees directly from the employer's funds, thereby assuming  
 459 the financial risks rather than passing them on to an outside insurer through premium  
 460 payments.

461 (15) "Plan" means the plan developed and adopted by the Health Data Committee  
 462 under Section 26-33a-104.

463 (16) "Third party payor" means [any]:

464 (a) an insurer offering a health [care insurance] benefit plan, as defined by Section  
 465 31A-1-301, [any] to at least 2,500 enrollees in the state;

466 (b) a nonprofit health service insurance corporation licensed under Title 31A, Chapter  
 467 7, Nonprofit Health Service Insurance Corporations[~~, any~~];

468 (c) a program funded or administered by [the state of] Utah for the provision of health  
 469 care services, including the Medicaid and medical assistance programs described in [Title 26,  
 470 Chapter 18[~~, or any other similar~~], Medical Assistance Act; and

471 (d) a corporation, organization, association, entity, or person[-];

472 (i) which administers or offers a health benefit plan to at least 2,500 enrollees in the  
 473 state; and

474 (ii) which is required by administrative rule adopted by the department in accordance  
 475 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to supply health data to the  
 476 committee.

477 Section 5. Section **26-33a-103** is amended to read:

478 **26-33a-103. Committee membership -- Terms -- Chair -- Compensation.**

479 (1) The Health Data Committee created by Section 26-1-7 shall be composed of [~~13~~]  
 480 14 members appointed by the governor with the consent of the Senate.

481 (2) No more than seven members of the committee may be members of the same  
 482 political party.

483 (3) The appointed members of the committee shall be knowledgeable regarding the  
 484 health care system and the characteristics and use of health data and shall be selected so that  
 485 the committee at all times includes individuals who provide care.

486 (4) The membership of the committee shall be:

487 (a) one person employed by or otherwise associated with a hospital as defined by  
 488 Section 26-21-2, who is knowledgeable about the collection, analysis, and use of health care  
 489 data;

490 (b) [~~one physician~~] two physicians, as defined in Section 58-67-102[;]:

491 (i) who are licensed to practice in this state[; ~~who spends the majority of his time in the~~  
 492 ~~practice of~~];

493 (ii) who actively practice medicine in this state;

494 (iii) who are trained in or have experience with the collection, analysis, and use of  
 495 health care data; and

496 (iv) one of whom is selected by the Utah Medical Association;

497 [~~(e) one registered nurse licensed to practice in this state under Title 58, Chapter 31b,~~  
 498 ~~Nurse Practice Act;~~]

499 [~~(d)~~] (c) three persons;

500 (i) who are:

501 (A) employed by or otherwise associated with a business that supplies health care  
 502 insurance to its employees[;]; and

503 (B) knowledgeable about the collection and use of health care data; and

504 (ii) at least one of whom represents an employer employing 50 or fewer employees;

505 [~~(e) one person~~] (d) three persons representing health insurers;

506 (i) at least one of whom is employed by or associated with a third-party payor that is  
 507 not licensed under Title 31A, Chapter 8, Health Maintenance Organizations and Limited  
 508 Health Plans;

509 (ii) at least one of whom is employed by or associated with a third party payer that is  
 510 licensed under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health  
 511 Plans; and

512 (iii) who are trained in, or experienced with the collection, analysis, and use of health  
 513 care data;

514 ~~[(f)]~~ (e) two consumer representatives;

515 (i) from organized consumer or employee associations; and

516 (ii) knowledgeable about the collection and use of health care data;

517 ~~[(g)]~~ (f) one person [broadly];

518 (i) representative of [the public interest;] a neutral, non-biased entity that can  
 519 demonstrate that it has the broad support of health care payers and health care providers; and

520 (ii) who is knowledgeable about the collection, analysis, and use of health care data;

521 and

522 ~~[(h) one person employed by or associated with an organization that is licensed under~~  
 523 ~~Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans; and]~~

524 ~~[(i)]~~ (g) two [people] persons representing public health who are trained in, or  
 525 experienced with the collection, use, and analysis of health care data.

526 (5) (a) Except as required by Subsection (5)(b), as terms of current committee members  
 527 expire, the governor shall appoint each new member or reappointed member to a four-year  
 528 term.

529 (b) Notwithstanding the requirements of Subsection (5)(a), the governor shall[-];

530 (i) at the time of appointment or reappointment, adjust the length of terms to ensure  
 531 that the terms of committee members are staggered so that approximately half of the committee  
 532 is appointed every two years[-]; and

533 (ii) prior to July 1, 2011, re-appoint the members described in Subsections (4)(b), (d),

534 and (f) as necessary to comply with changes in eligibility for membership that were enacted  
535 during the 2011 General Session.

536 (c) Members may serve after their terms expire until replaced.

537 (6) When a vacancy occurs in the membership for any reason, the replacement shall be  
538 appointed for the unexpired term.

539 (7) Committee members shall annually elect a chair of the committee from among their  
540 membership. The chair shall report to the executive director.

541 (8) The committee shall meet at least once during each calendar quarter. Meeting dates  
542 shall be set by the chair upon 10 working days notice to the other members, or upon written  
543 request by at least four committee members with at least 10 working days notice to other  
544 committee members.

545 (9) Seven committee members constitute a quorum for the transaction of business.  
546 Action may not be taken except upon the affirmative vote of a majority of a quorum of the  
547 committee.

548 (10) A member may not receive compensation or benefits for the member's service, but  
549 may receive per diem and travel expenses in accordance with:

550 (a) Section 63A-3-106;

551 (b) Section 63A-3-107; and

552 (c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and  
553 63A-3-107.

554 (11) All meetings of the committee shall be open to the public, except that the  
555 committee may hold a closed meeting if the requirements of Sections 52-4-204, 52-4-205, and  
556 52-4-206 are met.

557 Section 6. Section **26-33a-106.5** is amended to read:

558 **26-33a-106.5. Comparative analyses.**

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

562 (2) (a) The committee shall publish compilations or reports from the data it collects  
563 under this chapter or from any other source which:

- 564 (i) contain the information described in Subsection (2)(b); and
- 565 (ii) compare and identify by name at least a majority of the health care facilities and  
566 institutions in the state.

567 (b) The report required by this Subsection (2) shall:

- 568 (i) be published at least annually; and
- 569 (ii) contain comparisons based on at least the following factors:
  - 570 (A) nationally or other generally recognized quality standards;
  - 571 (B) charges; and
  - 572 (C) nationally recognized patient safety standards.

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

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

583 (5) The comparative analysis required under Subsection (2) shall be available;

- 584 (a) free of charge and easily accessible to the public[-]; and
- 585 (b) on the Health Insurance Exchange either directly or through a link.

586 (6) (a) On or before December 1, 2011, the department shall include in the report  
587 required by Subsection (2)(b), or include in a separate report, comparative information on  
588 commonly recognized or generally agreed upon measures of quality identified in accordance  
589 with Subsection (7), for:

590 (i) routine and preventive care; and

591 (ii) the treatment of diabetes, heart disease, and other illnesses or conditions.

592 (b) The comparative information required by Subsection (6)(a) shall be based on data  
593 collected under Subsection (2) and clinical data that may be available to the committee, and  
594 shall be reported as a statewide aggregate for facilities and clinics.

595 (c) The department shall, in accordance with Subsection (7)(c), publish reports on or  
596 after July 1, 2012, based on the quality measures described in Subsection (6)(a), using the data  
597 collected under Subsection (2) and clinical data that may be available to the committee, that  
598 compare:

599 (i) results for health care facilities or institutions;

600 (ii) a clinic's aggregate results for a physician who practices at a clinic with five or  
601 more physicians; and

602 (iii) a geographic region's aggregate results for a physician who practices at a clinic  
603 with less than five physicians, unless the physician requests physician-level data to be  
604 published on a clinic level.

605 (d) The department:

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

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

610 (iii) shall identify and report to the Legislature's Health and Human Services Interim  
611 Committee by July 1, 2012, and every July 1, thereafter until July 1, 2015, at least five new  
612 measures of quality to be added to the report each year.

613 (e) A report published by the department under this Subsection (6):

614 (i) is subject to the requirements of Section 26-33a-107; and

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

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

622 (b) If the entity described in Subsection (7)(a) does not submit the quality measures  
623 prior to July 1, 2011, the department may select the appropriate number of quality measures for  
624 purposes of the report required by Subsection (6).

625 (c) (i) For purposes of the reports published on or after July 1, 2012, the department  
626 may not compare individual facilities or clinics as described in Subsections (6)(c)(i) through  
627 (iii) if the department determines that the data available to the department can not be  
628 appropriately validated, does not represent nationally recognized measures, does not reflect the  
629 mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing  
630 providers.

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

633 (d) The committee and the department shall report to the Legislature's Health System  
634 Reform Task Force on or before November 1, 2011, regarding the department's progress in  
635 creating a system to validate the data and address the issues described in Subsection(7)(c).

636 Section 7. Section **26-40-106** is amended to read:

637 **26-40-106. Program benefits.**

638 (1) Until the department implements a plan under Subsection (2), program benefits  
639 may include:

640 (a) hospital services;

641 (b) physician services;

642 (c) laboratory services;

643 (d) prescription drugs;

644 (e) mental health services;

645 (f) basic dental services;

646 (g) preventive care including:

647 (i) routine physical examinations;

648 (ii) immunizations;

649 (iii) basic vision services; and

650 (iv) basic hearing services;

651 (h) limited home health and durable medical equipment services; and

652 (i) hospice care.

653 (2) (a) Except as provided in Subsection (2)~~(c)~~(d), no later than July 1, 2008, the  
654 program benefits shall be benchmarked, in accordance with 42 U.S.C. 1397cc, to be actuarially  
655 equivalent to a health benefit plan with the largest insured commercial enrollment offered by a  
656 health maintenance organization in the state.

657 (b) Except as provided in Subsection (2)~~(c)~~(d), after July 1, 2008:

658 (i) program benefits may not exceed the benefit level described in Subsection (2)(a);

659 and

660 (ii) program benefits shall be adjusted every July 1, thereafter to meet the benefit level  
661 described in Subsection (2)(a).

662 (c) The dental benefit plan shall be benchmarked, in accordance with the Children's  
663 Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit  
664 plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is  
665 offered in the state.

666 ~~(c)~~ (d) The program benefits for enrollees who are at or below 100% of the federal  
667 poverty level are exempt from the benchmark requirements of Subsections (2)(a) and (2)(b).

668 Section 8. Section **26-40-115** is enacted to read:

669 **26-40-115. State contractor -- Employee and dependent health benefit plan**  
670 **coverage.**

671 For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205, 63C-9-403, 72-6-107.5,  
672 and 79-2-404, "qualified health insurance coverage" means at the time the contract is entered  
673 into or renewed:



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

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

681 (b) for purposes of calculating actuarial equivalency under this Subsection (1)(b):

682 (i) rather than the benchmark plan's deductible, and the benchmark plan's out-of-pocket  
683 maximum based on income levels:

684 (A) the deductible is \$1,000 per individual and \$3,000 per family; and

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

686 (ii) dental coverage is not required; and

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

689 (2) a federally qualified high deductible health plan that, at a minimum:

690 (a) has a deductible that is either:

691 (i) the lowest deductible permitted for a federally qualified high deductible health plan;

692 or

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

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

700 (c) the employer pays 60% of the premium for the employee and the dependents of the  
701 employee who work or reside in the state.

702 Section 9. Section **31A-2-212** is amended to read:

703 **31A-2-212. Miscellaneous duties.**

704 (1) Upon issuance of any order limiting, suspending, or revoking an insurer's authority  
705 to do business in Utah, and on institution of any proceedings against the insurer under Chapter  
706 27a, Insurer Receivership Act, the commissioner:

707 (a) shall notify by mail all agents of the insurer of whom the commissioner has record;  
708 and

709 (b) may publish notice of the order or proceeding in any manner the commissioner  
710 considers necessary to protect the rights of the public.

711 (2) When required for evidence in any legal proceeding, the commissioner shall furnish  
712 a certificate of the authority of any licensee to transact insurance business in Utah on any  
713 particular date. The court or other officer shall receive the certificate of authority in lieu of the  
714 commissioner's testimony.

715 (3) (a) On the request of any insurer authorized to do a surety business, the  
716 commissioner shall furnish a copy of the insurer's certificate of authority to any designated  
717 public officer in this state who requires that certificate of authority before accepting a bond.

718 (b) The public officer described in Subsection (3)(a) shall file the certificate of  
719 authority furnished under Subsection (3)(a).

720 (c) After a certified copy of a certificate of authority has been furnished to a public  
721 officer, it is not necessary, while the certificate of authority remains effective, to attach a copy  
722 of it to any instrument of suretyship filed with that public officer.

723 (d) Whenever the commissioner revokes the certificate of authority or starts  
724 proceedings under Chapter 27a, Insurer Receivership Act, against any insurer authorized to do  
725 a surety business, the commissioner shall immediately give notice of that action to each public  
726 officer who was sent a certified copy under this Subsection (3).

727 (4) (a) The commissioner shall immediately notify every judge and clerk of all courts  
728 of record in the state when:

729 (i) an authorized insurer doing a surety business:

730 (A) files a petition for receivership; or  
731 (B) is in receivership; or  
732 (ii) the commissioner has reason to believe that the authorized insurer doing surety  
733 business:  
734 (A) is in financial difficulty; or  
735 (B) has unreasonably failed to carry out any of its contracts.  
736 (b) Upon the receipt of the notice required by this Subsection (4) it is the duty of the  
737 judges and clerks to notify and require every person that has filed with the court a bond on  
738 which the authorized insurer doing surety business is surety, to immediately file a new bond  
739 with a new surety.  
740 (5) The commissioner shall require an insurer that issues, sells, renews, or offers health  
741 insurance coverage in this state to comply with:  
742 (a) the Health Insurance Portability and Accountability Act, [~~P.L. 104-191~~] Pub. L. No.  
743 104-191, pursuant to 110 Stat. 1968, Sec. 2722[-]; and  
744 (b) subject to Section 63M-1-2505.5, and to the extent required or applicable under the  
745 provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the  
746 Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, related to regulation  
747 of health benefit plans, including:  
748 (i) lifetime and annual limits;  
749 (ii) prohibition of rescissions;  
750 (iii) coverage of preventive health services;  
751 (iv) coverage for a child or dependent;  
752 (v) pre-existing condition coverage for children;  
753 (vi) insurer transparency of consumer information including plan disclosures, uniform  
754 coverage documents, and standard definitions;  
755 (vii) premium rate reviews;  
756 (viii) essential benefits;  
757 (ix) provider choice;

758 (x) waiting periods; and

759 (xi) appeals processes.

760 Section 10. Section **31A-22-613.5** is amended to read:

761 **31A-22-613.5. Price and value comparisons of health insurance.**

762 (1) (a) This section applies to all health benefit plans.

763 (b) Subsection (2) applies to:

764 (i) all health benefit plans; and

765 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

766 (2) (a) The commissioner shall promote informed consumer behavior and responsible  
767 health benefit plans by requiring an insurer issuing a health benefit plan to:

768 (i) provide to all enrollees, prior to enrollment in the health benefit plan written  
769 disclosure of:

770 (A) restrictions or limitations on prescription drugs and biologics including:

771 (I) the use of a formulary;

772 (II) co-payments and deductibles for prescription drugs; and

773 (III) requirements for generic substitution;

774 (B) coverage limits under the plan; and

775 (C) any limitation or exclusion of coverage including:

776 (I) a limitation or exclusion for a secondary medical condition related to a limitation or  
777 exclusion from coverage; and

778 (II) easily understood examples of a limitation or exclusion of coverage for a secondary  
779 medical condition; and

780 (ii) provide the commissioner with:

781 (A) the information described in Subsections [~~63M-1-2506(3) through (6)~~]

782 31A-22-635(5) through (7) in the standardized electronic format required by Subsection

783 63M-1-2506(1); and

784 (B) information regarding insurer transparency in accordance with Subsection [~~(5)~~] (4).

785 (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to

786 the commissioner:

- 787 (i) upon commencement of operations in the state; and
- 788 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
  - 789 (A) treatment policies;
  - 790 (B) practice standards;
  - 791 (C) restrictions;
  - 792 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
  - 793 (E) limitations or exclusions of coverage including a limitation or exclusion for a
  - 794 secondary medical condition related to a limitation or exclusion of the insurer's health
  - 795 insurance plan.

796 (c) An insurer shall provide the enrollee with notice of an increase in costs for  
797 prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):

- 798 (i) either:
  - 799 (A) in writing; or
  - 800 (B) on the insurer's website; and
- 801 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
- 802 soon as reasonably possible.

803 (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make  
804 available to prospective enrollees and maintain evidence of the fact of the disclosure of:

- 805 (i) the drugs included;
- 806 (ii) the patented drugs not included;
- 807 (iii) any conditions that exist as a precedent to coverage; and
- 808 (iv) any exclusion from coverage for secondary medical conditions that may result
- 809 from the use of an excluded drug.

810 (e) (i) The [~~department~~] commissioner shall develop examples of limitations or  
811 exclusions of a secondary medical condition that an insurer may use under Subsection  
812 (2)(a)(i)(C).

813 (ii) Examples of a limitation or exclusion of coverage provided under Subsection

814 (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact  
815 situation to fall within the description of an example does not, by itself, support a finding of  
816 coverage.

817 ~~[(3) An insurer who offers a health benefit plan under Chapter 30, Individual, Small~~  
818 ~~Employer, and Group Health Insurance Act, shall offer a basic health care plan subject to the~~  
819 ~~open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health~~  
820 ~~Insurance Act, that:]~~

821 ~~[(a) is a federally qualified high deductible health plan;]~~

822 ~~[(b) has a deductible that is within \$250 of the lowest deductible that qualifies under a~~  
823 ~~federally qualified high deductible health plan, as adjusted by federal law; and]~~

824 ~~[(c) does not exceed an annual out of pocket maximum equal to three times the amount~~  
825 ~~of the annual deductible.]~~

826 ~~[(4)]~~ (3) The commissioner:

827 (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to  
828 the Health Insurance Exchange created under Section 63M-1-2504; and

829 (b) may request information from an insurer to verify the information submitted by the  
830 insurer under this section.

831 ~~[(5)]~~ (4) The commissioner shall:

832 (a) convene a group of insurers, a member representing the Public Employees' Benefit  
833 and Insurance Program, consumers, and an organization described in Subsection  
834 31A-22-614.6(3)(b), to develop information for consumers to compare health insurers and  
835 health benefit plans on the Health Insurance Exchange, which shall include consideration of:

836 (i) the number and cost of an insurer's denied health claims;

837 (ii) the cost of denied claims that is transferred to providers;

838 (iii) the average out-of-pocket expenses incurred by participants in each health benefit  
839 plan that is offered by an insurer in the Health Insurance Exchange;

840 (iv) the relative efficiency and quality of claims administration and other administrative  
841 processes for each insurer offering plans in the Health Insurance Exchange; and

- 842 (v) consumer assessment of each insurer or health benefit plan;
- 843 (b) adopt an administrative rule that establishes:
  - 844 (i) definition of terms;
  - 845 (ii) the methodology for determining and comparing the insurer transparency
  - 846 information;
  - 847 (iii) the data, and format of the data, that an insurer must submit to the [department]
  - 848 commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange
  - 849 in accordance with Section 63M-1-2506; and
  - 850 (iv) the dates on which the insurer must submit the data to the [department]
  - 851 commissioner in order for the [department] commissioner to transmit the data to the Health
  - 852 Insurance Exchange in accordance with Section 63M-1-2506; and
  - 853 (c) implement the rules adopted under Subsection [~~(5)~~] (4)(b) in a manner that protects
  - 854 the business confidentiality of the insurer.

855 Section 11. Section **31A-22-614.6** is amended to read:

856 **31A-22-614.6. Health care delivery and payment reform demonstration projects.**

857 (1) The Legislature finds that:

- 858 (a) current health care delivery and payment systems do not provide systemwide
- 859 aligned incentives for the appropriate delivery of health care;
- 860 (b) some health care providers and health care payers have developed ideas for health
- 861 care delivery and payment system reform, but lack the critical number of patient lives and
- 862 payer involvement to accomplish systemwide reform; and
- 863 (c) there is a compelling state interest to encourage [as many] health care providers and
- 864 health care payers to join together and coordinate efforts at systemwide health care delivery and
- 865 payment reform.

866 (2) (a) The [~~Office of Consumer Health Services within the Governor's Office of~~

867 ~~Economic Development shall~~] Department of Health may convene meetings of health care

868 providers and health care payers [~~through a neutral, non-biased entity that can demonstrate it~~

869 ~~has the support of a broad base of the participants in this process~~] for the purpose of

870 coordinating broad based demonstration projects for health care delivery and payment reform.

871 (b) (i) The speaker of the House of Representatives may appoint a person who is a  
872 member of the House of Representatives, or from the Office of Legislative Research and  
873 General Counsel, to attend the meetings convened under Subsection (2)(a).

874 (ii) The president of the Senate may appoint a person who is a senator, or from the  
875 Office of Legislative Research and General Counsel, to attend the meetings convened under  
876 Subsection (2)(a).

877 (c) Participation in the coordination efforts by health care providers and health care  
878 payers is voluntary, but is encouraged.

879 (3) The commissioner and the [~~Office of Consumer Health Services shall~~] Department  
880 of Health may facilitate several coordinated broad based demonstration projects for health care  
881 delivery reform and health care payment reform between one or more health care providers and  
882 one or more health care payers who elect to participate in the demonstration projects by:

883 (a) consulting with health care providers and health care payers who elect to join  
884 together in a broad based reform demonstration project;

885 (b) consulting with a neutral, non-biased third party with an established record for  
886 broad based, multi-payer and multi-provider quality assurance efforts and data collection;

887 (c) applying for grants and assistance that may be available for creating and  
888 implementing the demonstration projects; and

889 (d) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah  
890 Administrative Rulemaking Act, as necessary to develop, oversee, and implement the  
891 demonstration projects.

892 (4) The [~~Office of Consumer Health Services~~] Department of Health and the  
893 commissioner shall report to the Health System Reform Task Force by October [~~2010~~] 2011,  
894 and to the Legislature's Business and Labor Interim Committee every October thereafter  
895 regarding the progress towards coordination of broad based health care system payment and  
896 delivery reform.

897 Section 12. Section **31A-22-625** is amended to read:



898           **31A-22-625. Catastrophic coverage of mental health conditions.**

899           (1) As used in this section:

900           (a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan  
901 that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or  
902 outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden  
903 on an insured for the evaluation and treatment of a mental health condition than for the  
904 evaluation and treatment of a physical health condition.

905           (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing  
906 factors, such as deductibles, copayments, or coinsurance, before reaching a maximum  
907 out-of-pocket limit.

908           (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket  
909 limit for physical health conditions and another maximum out-of-pocket limit for mental health  
910 conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit  
911 for mental health conditions may not exceed the out-of-pocket limit for physical health  
912 conditions.

913           (b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that  
914 pays for at least 50% of covered services for the diagnosis and treatment of mental health  
915 conditions.

916           (ii) "50/50 mental health coverage" may include a restriction on:

- 917           (A) episodic limits;
- 918           (B) inpatient or outpatient service limits; or
- 919           (C) maximum out-of-pocket limits.

920           (c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

921           (d) (i) "Mental health condition" means a condition or disorder involving mental illness  
922 that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as  
923 periodically revised.

924           (ii) "Mental health condition" does not include the following when diagnosed as the  
925 primary or substantial reason or need for treatment:

- 926 (A) a marital or family problem;
  - 927 (B) a social, occupational, religious, or other social maladjustment;
  - 928 (C) a conduct disorder;
  - 929 (D) a chronic adjustment disorder;
  - 930 (E) a psychosexual disorder;
  - 931 (F) a chronic organic brain syndrome;
  - 932 (G) a personality disorder;
  - 933 (H) a specific developmental disorder or learning disability; or
  - 934 (I) mental retardation.
- 935 (e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.
- 936 (2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer
- 937 that it insures or seeks to insure a choice between:
- 938 (i) (A) catastrophic mental health coverage [~~and~~]; or
  - 939 (B) federally qualified mental health coverage as described in Subsection (3); and
  - 940 (ii) 50/50 mental health coverage.
- 941 (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:
- 942 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels
  - 943 that exceed the minimum requirements of this section; or
  - 944 (ii) coverage that excludes benefits for mental health conditions.
- 945 (c) A small employer may, at its option, regardless of the employer's previous coverage
- 946 for mental health conditions, choose either [~~catastrophic mental health coverage, 50/50 mental~~
- 947 ~~health coverage, or~~]:
- 948 (i) coverage offered under Subsection (2)(a)(i);
  - 949 (ii) 50/50 mental health coverage; or
  - 950 (iii) coverage offered under Subsection (2)(b)[~~, regardless of the employer's previous~~
  - 951 ~~coverage for mental health conditions]~~.
- 952 (d) An insurer is exempt from the 30% index rating restriction in Section
- 953 31A-30-106.1 and, for the first year only that catastrophic mental health coverage is chosen, the

954 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or  
955 less enrolled employees who chooses coverage that meets or exceeds catastrophic mental  
956 health coverage.

957 (3) An insurer shall offer a large employer mental health and substance use disorder  
958 benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec.  
959 300gg-5, and federal regulations adopted pursuant to that act.

960 (4) (a) An insurer may provide catastrophic mental health coverage to a small employer  
961 through a managed care organization or system in a manner consistent with Chapter 8, Health  
962 Maintenance Organizations and Limited Health Plans, regardless of whether the insurance  
963 policy uses a managed care organization or system for the treatment of physical health  
964 conditions.

965 (b) (i) Notwithstanding any other provision of this title, an insurer may:

966 (A) establish a closed panel of providers for catastrophic mental health coverage; and

967 (B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider  
968 unless:

969 (I) the insured is referred to a nonpanel provider with the prior authorization of the  
970 insurer; and

971 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment  
972 guidelines.

973 (ii) If an insured receives services from a nonpanel provider in the manner permitted by  
974 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the  
975 average amount paid by the insurer for comparable services of panel providers under a  
976 noncapitated arrangement who are members of the same class of health care providers.

977 (iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a  
978 referral to a nonpanel provider.

979 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a  
980 mental health condition must be rendered:

981 (i) by a mental health therapist as defined in Section 58-60-102; or

982 (ii) in a health care facility:  
 983 (A) licensed or otherwise authorized to provide mental health services pursuant to:  
 984 (I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or  
 985 (II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and  
 986 (B) that provides a program for the treatment of a mental health condition pursuant to a  
 987 written plan.

988 (5) The commissioner may prohibit an insurance policy that provides mental health  
 989 coverage in a manner that is inconsistent with this section.

990 (6) The commissioner shall:

991 (a) adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative  
 992 Rulemaking Act, as necessary to ensure compliance with this section; and

993 (b) provide general figures on the percentage of insurance policies that include:

994 (i) no mental health coverage;

995 (ii) 50/50 mental health coverage;

996 (iii) catastrophic mental health coverage; and

997 (iv) coverage that exceeds the minimum requirements of this section.

998 (7) This section may not be construed as discouraging or otherwise preventing an  
 999 insurer from providing mental health coverage in connection with an individual insurance  
 1000 policy.

1001 (8) This section shall be repealed in accordance with Section 63I-1-231.

1002 Section 13. Section **31A-22-635** is amended to read:

1003 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**  
 1004 **on Health Insurance Exchange.**

1005 (1) For purposes of this section, "insurer":

1006 (a) is defined in Subsection 31A-22-634(1); and

1007 (b) includes the state employee's risk pool under Section 49-20-202.

1008 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall[:  
 1009 ~~(i) except as provided in Subsection (6);]~~ use a uniform application form[~~;~~ which, beginning

1010 ~~October 1, 2010;]~~

1011 (b) The uniform application form:

1012 ~~[(A)] (i)~~ except for cancer and transplants, may not include questions about an  
1013 applicant's health history prior to the previous ~~[+0]~~ five years; and

1014 ~~[(B)] (ii)~~ shall be shortened and simplified in accordance with rules adopted by the  
1015 ~~[department; and]~~ commissioner.

1016 ~~[(+)] (c)~~ Insurers offering a health benefit plan to a small employer shall use a uniform  
1017 waiver of coverage form, which~~[-(A)]~~ may not include health status related questions other  
1018 than pregnancy~~[-];~~, and ~~[(B)]~~ is limited to:

1019 ~~[(+)] (i)~~ information that identifies the employee;

1020 ~~[(+)] (ii)~~ proof of the employee's insurance coverage; and

1021 ~~[(+)] (iii)~~ a statement that the employee declines coverage with a particular employer  
1022 group.

1023 ~~[(b)] (3)~~ Notwithstanding the requirements of Subsection (2)(a), the uniform  
1024 application and uniform waiver of coverage forms may be combined or modified to facilitate~~[-]~~  
1025 a more efficient and consumer friendly experience for enrollees using the Health Insurance  
1026 Exchange if the modification is approved by the commissioner.

1027 ~~[(i) the electronic submission and processing of an application through the Health~~  
1028 ~~Insurance Exchange created pursuant to Section 63M-1-2504 or directly to all carriers; and]~~

1029 ~~[(ii) a more efficient and understandable experience for a consumer submitting an~~  
1030 ~~application in the Health Insurance Exchange or directly to all carriers.]~~

1031 ~~[(3) An insurer offering a defined contribution arrangement health benefit plan in the~~  
1032 ~~Health Insurance Exchange to a large group shall use a large group uniform application, and~~  
1033 ~~uniform waiver of coverage form, that is adopted by the department by administrative rule.]~~

1034 (4) ~~[(a)(+)]~~ The uniform application form, and uniform waiver form, shall be adopted  
1035 and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah  
1036 Administrative Rulemaking Act.

1037 ~~[(ii) Modifications to the uniform application necessary to facilitate the electronic~~

1038 ~~submission and processing of an application through the Health Insurance Exchange shall be~~  
1039 ~~adopted by administrative rule adopted by the Office of Consumer Health Services in~~  
1040 ~~accordance with Section 63M-1-2506.]~~

1041 ~~[(b) The commissioner shall convene the health insurance industry, the Office of~~  
1042 ~~Consumer Health Services, and consumers to review the uniform application for the individual~~  
1043 ~~and small group market, and the large group market, and make recommendations regarding the~~  
1044 ~~uniform applications. The department shall report the findings of the group convened pursuant~~  
1045 ~~to this Subsection (4)(b) to the Legislature no later than July 1, 2010.]~~

1046 (5) (a) ~~[Beginning October 1, 2010, an]~~ An insurer who offers a health benefit plan in  
1047 either the group or individual market on the Health Insurance Exchange created in Section  
1048 63M-1-2504, shall:

1049 (i) accept and process an electronic submission of the uniform application or uniform  
1050 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to  
1051 Section 63M-1-2506; [and]

1052 (ii) if requested, provide the applicant with a copy of the completed application either  
1053 by mail or electronically[-];

1054 (iii) post all health benefit plans offered by the insurer in the defined contribution  
1055 arrangement market on the Health Insurance Exchange; and

1056 (iv) post the information required by Subsection (6) on the Health Insurance Exchange  
1057 for every health benefit plan the insurer offers on the Health Insurance Exchange.

1058 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans  
1059 on the Health Insurance Exchange may not directly or indirectly offer products on the Health  
1060 Insurance Exchange that are not health benefit plans.

1061 (c) Notwithstanding Subsection (5)(b), an insurer may offer a health savings account  
1062 on the Health Insurance Exchange.

1063 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with  
1064 the following information for each health benefit plan submitted to the Health Insurance  
1065 Exchange, in the electronic format required by Subsection 63M-1-2506(1):

1066 (a) plan design, benefits, and options offered by the health benefit plan including state  
 1067 mandates the plan does not cover;

1068 (b) information and Internet address to online provider networks;

1069 (c) wellness programs and incentives;

1070 (d) descriptions of prescription drug benefits, exclusions, or limitations;

1071 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is  
 1072 submitted to the insurer for the prior year; and

1073 (f) the claims denial and insurer transparency information developed in accordance  
 1074 with Subsection 31A-22-613.5(4).

1075 (7) The Insurance Department shall post on the Health Insurance Exchange the  
 1076 Insurance Department's solvency rating for each insurer who posts a health benefit plan on the  
 1077 Health Insurance Exchange. The solvency rating for each insurer shall be based on  
 1078 methodology established by the Insurance Department by administrative rule and shall be  
 1079 updated each calendar year.

1080 (8) (a) The commissioner may request information from an insurer under Section  
 1081 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health  
 1082 Insurance Exchange.

1083 (b) The commissioner shall regulate any fees charged by insurers to an enrollee for a  
 1084 uniform application form or electronic submission of the application forms.

1085 ~~[(6) An insurer offering a health benefit plan outside the Health Insurance Exchange~~  
 1086 ~~may use the uniform application in effect prior to May 15, 2010, until January 1, 2011.]~~

1087 Section 14. Section **31A-22-724** is amended to read:

1088 **31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**

1089 (1) For purposes of this section, "alternative coverage" means:

1090 (a) ~~[the]~~ a high deductible or low deductible Utah NetCare Plan described in  
 1091 Subsection (2) for a conversion ~~[policies]~~ health benefit plan policy offered under Section  
 1092 31A-22-723; and

1093 (b) ~~[the]~~ a high deductible and low deductible Utah NetCare Plans described in

1094 Subsection (2) as an alternative to COBRA and mini-COBRA [~~policies~~] health benefit plan  
1095 coverage offered under Section 31A-22-722.

1096 (2) [~~The~~] A Utah NetCare [Plans] Plan under this section is subject to Section  
1097 31A-2-212 and shall, except when prohibited by federal law, include:

1098 (a) healthy lifestyle and wellness incentives;

1099 (b) the benefits described in this Subsection (2) or at least the actuarial equivalent of  
1100 the benefits described in this Subsection (2);

1101 (c) a lifetime maximum benefit per person of not less than \$1,000,000;

1102 (d) an annual maximum benefit per person of not less than \$250,000;

1103 (e) the following deductibles:

1104 (i) for [~~the~~] a low deductible [plans] plan:

1105 (A) \$2,000 for an individual plan;

1106 (B) \$4,000 for a two party plan; and

1107 (C) \$6,000 for a family plan;

1108 (ii) for [~~the~~] a high deductible [plans] plan:

1109 (A) \$4,000 for an individual plan;

1110 (B) \$8,000 for a two party plan; and

1111 (C) \$12,000 for a family plan;

1112 (f) the following out-of-pocket maximum costs, including deductibles, copayments,  
1113 and coinsurance:

1114 (i) for [~~the~~] a low deductible [plans] plan:

1115 (A) \$5,000 for an individual plan;

1116 (B) \$10,000 for a two party plan; and

1117 (C) \$15,000 for a family plan; and

1118 (ii) for [~~the~~] a high deductible plan:

1119 (A) \$10,000 for an individual plan;

1120 (B) \$20,000 for a two party plan; and

1121 (C) \$30,000 for a family plan;



1122 (g) the following benefits before applying [~~any~~] a deductible [~~requirements~~]  
1123 requirement and in accordance with [~~IRC~~] Section 223, Internal Revenue Code, and 42 U.S.C.  
1124 Sec. 300gg-13:  
1125 (i) all well child exams and immunizations up to age five, with no annual maximum;  
1126 (ii) preventive care up to a \$500 annual maximum;  
1127 (iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i)  
1128 or (ii) up to a \$300 annual maximum; and  
1129 (iv) supplemental accident coverage up to a \$500 annual maximum;  
1130 (h) the following copayments for each exam:  
1131 (i) \$15 for preventive care and well child exams;  
1132 (ii) \$25 for primary care; and  
1133 (iii) \$50 for urgent care and specialist care;  
1134 (i) a \$200 copayment for an emergency room [~~visits~~] visit after applying the  
1135 deductible;  
1136 (j) no more than a 30% coinsurance after deductible for covered plan benefits for:  
1137 (i) hospital services[;];  
1138 (ii) maternity[;];  
1139 (iii) laboratory work[;];  
1140 (iv) x-rays[;];  
1141 (v) radiology[;];  
1142 (vi) outpatient surgery services[;];  
1143 (vii) injectable medications not otherwise covered under a pharmacy benefit[;];  
1144 (viii) durable medical equipment[;];  
1145 (ix) ambulance services[;];  
1146 (x) in-patient mental health services[;]; and  
1147 (xi) out-patient mental health services; and  
1148 (k) the following cost-sharing features for a prescription [~~drugs~~] drug:  
1149 (i) up to a \$15 copayment for a generic [~~drugs;~~] drug; and

1150 (ii) up to a 50% coinsurance for a name brand [drugs; and] drug.  
1151 [~~(iii) may include formularies and preferred drug lists.~~]  
1152 (3) ~~[The]~~ A Utah NetCare [Plans] Plan may exclude:  
1153 (a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and  
1154 (b) unless required by federal law, mandated coverage required by the following  
1155 sections and related administrative rules:  
1156 (i) Section 31A-22-610.1, Adoption indemnity [~~benefits~~] benefit;  
1157 (ii) Section 31A-22-623, Coverage of inborn metabolic errors;  
1158 (iii) Section 31A-22-624, Primary care [~~physicians~~] physician;  
1159 (iv) Section 31A-22-626, Coverage of diabetes;  
1160 (v) Section 31A-22-628, Standing referral to a specialist; and  
1161 (vi) [~~coverage mandates~~] a mandated coverage enacted after January 1, 2009, that [~~are~~]  
1162 is not required by federal law.  
1163 [~~(4)(a) Beginning January 1, 2010, and except~~]  
1164 (4) A Utah NetCare Plan may include a formulary or preferred drug list.  
1165 (5) (a) Except as provided in Subsection [~~(5)~~] (6), a person may elect alternative  
1166 coverage under this section if the person is eligible for:  
1167 (i) [~~is eligible for~~] continuation of employer group health benefit plan coverage under  
1168 federal COBRA laws;  
1169 (ii) [~~is eligible for~~] continuation of employer group health benefit plan coverage under  
1170 state mini-COBRA under Section 31A-22-722; or  
1171 (iii) [~~is eligible for~~] a conversion to an individual health benefit plan after the  
1172 exhaustion of benefits under:  
1173 (A) alternative coverage elected in place of federal COBRA; or  
1174 (B) state mini-COBRA under Section 31A-22-722.  
1175 (b) The right to extend coverage under Subsection [~~(4)~~] (5)(a) applies to [~~any~~] spouse  
1176 or dependent coverages, including a surviving spouse or dependent whose coverage under the  
1177 policy terminates by reason of the death of the employee or member.

1178           ~~[(5)]~~ (6) If a person elects federal COBRA ~~[coverage,]~~ or state mini-COBRA health  
1179 benefit plan coverage under Section 31A-22-722, the person is not eligible to elect alternative  
1180 coverage under this section until the person is eligible to convert coverage to an individual  
1181 policy under ~~[the provisions of]~~ Section 31A-22-723 and Subsection (1)(a).

1182           ~~[(6)]~~ (7) (a) (i) If ~~[the]~~ alternative coverage is selected as an alternative to COBRA or  
1183 mini-COBRA health benefit plan coverage under Section 31A-22-722, ~~[the provisions of]~~  
1184 Section 31A-22-722 ~~[apply]~~ applies to the alternative coverage.

1185           (ii) If an employee of a small employer selects alternative coverage as an alternative to  
1186 COBRA or mini-COBRA health benefit plan coverage, the insurer may not use a risk factor  
1187 greater than the employer's most current risk factor for purposes of Subsection 31A-22-722(5).

1188           (b) If ~~[the]~~ alternative coverage is selected as a conversion policy under Section  
1189 31A-22-723, ~~[the provisions of]~~ Section 31A-22-723 ~~[apply]~~ applies.

1190           ~~[(7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to~~  
1191 ~~September 1, 2009, file an alternative coverage policy with the department in accordance with~~  
1192 ~~Sections 31A-21-201 and 31A-21-201.1.]~~

1193           ~~[(b)]~~ (8) The ~~[department]~~ commissioner shall~~[-by November 1, 2009,]~~ adopt  
1194 administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking  
1195 Act, to develop a model letter for employers to use to notify an employee of the employee's  
1196 options for alternative coverage.

1197           Section 15. Section **31A-23a-115.5** is enacted to read:

1198           **31A-23a-115.5. Use of customer service representative.**

1199           A customer service representative licensed under this chapter:

1200           (1) may not maintain an office independent of the customer service representative's  
1201 licensed producer or consultant employer for the purpose of conducting insurance activities;

1202           (2) except as provided in Subsection (3), may not sell, solicit, negotiate, or bind  
1203 coverage; and

1204           (3) may provide a customer a quote on behalf of the customer service representative's  
1205 licensed producer or consultant employer.

1206 Section 16. Section 31A-29-103 is amended to read:

1207 **31A-29-103. Definitions.**

1208 As used in this chapter:

1209 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.

1210 (2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

1211 (b) "Creditable coverage" does not include a period of time in which there is a  
1212 significant break in coverage, as defined in Section 31A-1-301.

1213 (3) "Domicile" means the place where an individual has a fixed and permanent home  
1214 and principal establishment:

1215 (a) to which the individual, if absent, intends to return; and

1216 (b) in which the individual, and the individual's family voluntarily reside, not for a  
1217 special or temporary purpose, but with the intention of making a permanent home.

1218 (4) "Enrollee" means an individual who has met the eligibility requirements of the pool  
1219 and is covered by a pool policy under this chapter.

1220 (5) "Health benefit plan":

1221 (a) is defined in Section 31A-1-301; and

1222 (b) does not include a plan that:

1223 (i) (A) has a maximum actuarial value less ~~[that]~~ than 100% of ~~[the basic health care~~  
1224 ~~plan; or]~~ a health benefit plan described in Subsection (5)(c); or

1225 (B) has a maximum annual limit of \$100,000 or less; and

1226 (ii) meets other criteria established by the board.

1227 (c) For purposes of Subsection (5)(b)(i)(A) the health benefit plan shall:

1228 (i) be a federally qualified high deductible health plan;

1229 (ii) have a deductible that has the lowest deductible that qualifies as a federally  
1230 qualified high deductible health plan as adjusted by federal law; and

1231 (iii) not exceed an annual out-of-pocket maximum equal to three times the amount of  
1232 the deductible.

1233 (6) "Health care facility" means any entity providing health care services which is

- 1234 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.
- 1235 (7) "Health care insurance" is defined in Section 31A-1-301.
- 1236 (8) "Health care provider" has the same meaning as provided in Section 78B-3-403.
- 1237 (9) "Health care services" means:
- 1238 (a) any service or product:
- 1239 (i) used in furnishing to any individual medical care or hospitalization; or
- 1240 (ii) incidental to furnishing medical care or hospitalization; and
- 1241 (b) any other service or product furnished for the purpose of preventing, alleviating,
- 1242 curing, or healing human illness or injury.
- 1243 (10) "Health maintenance organization" has the same meaning as provided in Section
- 1244 31A-8-101.
- 1245 (11) "Health plan" means any arrangement by which an individual, including a
- 1246 dependent or spouse, covered or making application to be covered under the pool has:
- 1247 (a) access to hospital and medical benefits or reimbursement including group or
- 1248 individual insurance or subscriber contract;
- 1249 (b) coverage through:
- 1250 (i) a health maintenance organization;
- 1251 (ii) a preferred provider prepayment;
- 1252 (iii) group practice;
- 1253 (iv) individual practice plan; or
- 1254 (v) health care insurance;
- 1255 (c) coverage under an uninsured arrangement of group or group-type contracts
- 1256 including employer self-insured, cost-plus, or other benefits methodologies not involving
- 1257 insurance;
- 1258 (d) coverage under a group type contract which is not available to the general public
- 1259 and can be obtained only because of connection with a particular organization or group; and
- 1260 (e) coverage by Medicare or other governmental benefit.
- 1261 (12) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996,

1262 Pub. L. 104-191, 110 Stat. 1936.

1263 (13) "HIPAA eligible" means an individual who is eligible under the provisions of the  
1264 Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

1265 (14) "Insurer" means:

1266 (a) an insurance company authorized to transact accident and health insurance business  
1267 in this state;

1268 (b) a health maintenance organization; or

1269 (c) a self-insurer not subject to federal preemption.

1270 (15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.  
1271 Sec. 1396 et seq., as amended.

1272 (16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social  
1273 Security Act, 42 U.S.C. 1395 et seq., as amended.

1274 (17) "Plan of operation" means the plan developed by the board in accordance with  
1275 Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board  
1276 under Section 31A-29-106.

1277 (18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section  
1278 31A-29-104.

1279 (19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund  
1280 created in Section 31A-29-120.

1281 (20) "Pool policy" means a health benefit plan policy issued under this chapter.

1282 (21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

1283 (22) (a) "Resident" or "residency" means a person who is domiciled in this state.

1284 (b) A resident retains residency if that resident leaves this state:

1285 (i) to serve in the armed forces of the United States; or

1286 (ii) for religious or educational purposes.

1287 (23) "Third party administrator" has the same meaning as provided in Section  
1288 31A-1-301.

1289 Section 17. Section **31A-30-103** is amended to read:

1290 **31A-30-103. Definitions.**

1291 As used in this chapter:

1292 (1) "Actuarial certification" means a written statement by a member of the American  
1293 Academy of Actuaries or other individual approved by the commissioner that a covered carrier  
1294 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,  
1295 including review of the appropriate records and of the actuarial assumptions and methods used  
1296 by the covered carrier in establishing premium rates for applicable health benefit plans.

1297 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly  
1298 through one or more intermediaries, controls or is controlled by, or is under common control  
1299 with, a specified entity or person.

1300 (3) "Base premium rate" means, for each class of business as to a rating period, the  
1301 lowest premium rate charged or that could have been charged under a rating system for that  
1302 class of business by the covered carrier to covered insureds with similar case characteristics for  
1303 health benefit plans with the same or similar coverage.

1304 (4) "Basic benefit plan" or "basic coverage" means [~~the coverage provided in the Basic~~  
1305 ~~Health Care Plan under Section 31A-22-613.5.~~] a health benefit plan that:

1306 (a) until January 1, 2012:

1307 (i) is a federally qualified high deductible health plan;

1308 (ii) has a deductible that has the lowest deductible that qualifies as a federally qualified  
1309 high deductible health plan as adjusted by federal law; and

1310 (iii) does not exceed an annual out-of-pocket maximum equal to three times the  
1311 amount of the deductible; and

1312 (b) on or after January 1, 2012, is actuarially equivalent to the NetCare plan with the  
1313 highest actuarial value, as provided in Section 31A-22-724.

1314 (5) "Carrier" means any person or entity that provides health insurance in this state  
1315 including:

1316 (a) an insurance company;

1317 (b) a prepaid hospital or medical care plan;

- 1318 (c) a health maintenance organization;
- 1319 (d) a multiple employer welfare arrangement; and
- 1320 (e) any other person or entity providing a health insurance plan under this title.
- 1321 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
- 1322 demographic or other objective characteristics of a covered insured that are considered by the
- 1323 carrier in determining premium rates for the covered insured.
- 1324 (b) "Case characteristics" do not include:
- 1325 (i) duration of coverage since the policy was issued;
- 1326 (ii) claim experience; and
- 1327 (iii) health status.
- 1328 (7) "Class of business" means all or a separate grouping of covered insureds that is
- 1329 permitted by the department in accordance with Section 31A-30-105.
- 1330 (8) "Conversion policy" means a policy providing coverage under the conversion
- 1331 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.
- 1332 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
- 1333 this chapter.
- 1334 (10) "Covered individual" means any individual who is covered under a health benefit
- 1335 plan subject to this chapter.
- 1336 (11) "Covered insureds" means small employers and individuals who are issued a
- 1337 health benefit plan that is subject to this chapter.
- 1338 (12) "Dependent" means an individual to the extent that the individual is defined to be
- 1339 a dependent by:
- 1340 (a) the health benefit plan covering the covered individual; and
- 1341 (b) Chapter 22, Part 6, Accident and Health Insurance.
- 1342 (13) "Established geographic service area" means a geographical area approved by the
- 1343 commissioner within which the carrier is authorized to provide coverage.
- 1344 (14) "Index rate" means, for each class of business as to a rating period for covered
- 1345 insureds with similar case characteristics, the arithmetic average of the applicable base



1346 premium rate and the corresponding highest premium rate.

1347 (15) "Individual carrier" means a carrier that provides coverage on an individual basis  
1348 through a health benefit plan regardless of whether:

1349 (a) coverage is offered through:

1350 (i) an association;

1351 (ii) a trust;

1352 (iii) a discretionary group; or

1353 (iv) other similar groups; or

1354 (b) the policy or contract is situated out-of-state.

1355 (16) "Individual conversion policy" means a conversion policy issued to:

1356 (a) an individual; or

1357 (b) an individual with a family.

1358 (17) "Individual coverage count" means the number of natural persons covered under a  
1359 carrier's health benefit products that are individual policies.

1360 (18) "Individual enrollment cap" means the percentage set by the commissioner in  
1361 accordance with Section 31A-30-110.

1362 (19) "New business premium rate" means, for each class of business as to a rating  
1363 period, the lowest premium rate charged or offered, or that could have been charged or offered,  
1364 by the carrier to covered insureds with similar case characteristics for newly issued health  
1365 benefit plans with the same or similar coverage.

1366 (20) "Premium" means all money paid by covered insureds and covered individuals as  
1367 a condition of receiving coverage from a covered carrier, including any fees or other  
1368 contributions associated with the health benefit plan.

1369 (21) (a) "Rating period" means the calendar period for which premium rates  
1370 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1371 (b) A covered carrier may not have:

1372 (i) more than one rating period in any calendar month; and

1373 (ii) no more than 12 rating periods in any calendar year.

1374 (22) "Resident" means an individual who has resided in this state for at least 12  
1375 consecutive months immediately preceding the date of application.

1376 (23) "Short-term limited duration insurance" means a health benefit product that:

1377 (a) is not renewable; and

1378 (b) has an expiration date specified in the contract that is less than 364 days after the  
1379 date the plan became effective.

1380 (24) "Small employer carrier" means a carrier that provides health benefit plans  
1381 covering eligible employees of one or more small employers in this state, regardless of  
1382 whether:

1383 (a) coverage is offered through:

1384 (i) an association;

1385 (ii) a trust;

1386 (iii) a discretionary group; or

1387 (iv) other similar grouping; or

1388 (b) the policy or contract is situated out-of-state.

1389 (25) "Uninsurable" means an individual who:

1390 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the  
1391 underwriting criteria established in Subsection 31A-29-111(5); or

1392 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

1393 (ii) has a condition of health that does not meet consistently applied underwriting  
1394 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)  
1395 and (j) for which coverage the applicant is applying.

1396 (26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for  
1397 purposes of this formula:

1398 (a) "CI" means the carrier's individual coverage count as of December 31 of the  
1399 preceding year; and

1400 (b) "UC" means the number of uninsurable individuals who were issued an individual  
1401 policy on or after July 1, 1997.

1402 Section 18. Section **31A-30-104** is amended to read:  
1403 **31A-30-104. Applicability and scope.**  
1404 (1) This chapter applies to any:  
1405 (a) health benefit plan that provides coverage to:  
1406 (i) individuals;  
1407 (ii) small employers; or  
1408 (iii) both Subsections (1)(a)(i) and (ii); or  
1409 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and  
1410 31A-30-107.5.  
1411 (2) This chapter applies to a health benefit plan that provides coverage to small  
1412 employers or individuals regardless of:  
1413 (a) whether the contract is issued to:  
1414 (i) an association;  
1415 (ii) a trust;  
1416 (iii) a discretionary group; or  
1417 (iv) other similar grouping; or  
1418 (b) the situs of delivery of the policy or contract.  
1419 (3) This chapter does not apply to:  
1420 [~~(a) a large employer health benefit plan, except as specifically provided in Part 2,~~  
1421 ~~Defined Contribution Arrangements;~~]  
1422 [~~(b)~~] (a) short-term limited duration health insurance; or  
1423 [~~(c)~~] (b) federally funded or partially funded programs.  
1424 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:  
1425 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax  
1426 return shall be treated as one carrier; and  
1427 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health  
1428 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated  
1429 carriers were issued by one carrier.

1430 (b) Upon a finding of the commissioner, an affiliated carrier that is a health  
1431 maintenance organization having a certificate of authority under this title may be considered to  
1432 be a separate carrier for the purposes of this chapter.

1433 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined  
1434 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding  
1435 arrangements with respect to health benefit plans delivered or issued for delivery to covered  
1436 insureds in this state if the ceding arrangements would result in less than 50% of the insurance  
1437 obligation or risk for the health benefit plans being retained by the ceding carrier.

1438 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the  
1439 insurance obligation or risk with respect to one or more health benefit plans delivered or issued  
1440 for delivery to covered insureds in this state.

1441 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal  
1442 Labor Management Relations Act, or a carrier with the written authorization of such a trust,  
1443 may make a written request to the commissioner for a waiver from the application of any of the  
1444 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the  
1445 trust.

1446 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a  
1447 waiver if the commissioner finds that application with respect to the trust would:

1448 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;

1449 and

1450 (ii) require significant modifications to one or more collective bargaining arrangements  
1451 under which the trust is established or maintained.

1452 (c) A waiver granted under this Subsection (5) may not apply to an individual if the  
1453 person participates in a Taft Hartley trust as an associate member of any employee  
1454 organization.

1455 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and  
1456 31A-30-111 apply to:

1457 (a) any insurer engaging in the business of insurance related to the risk of a small

1458 employer for medical, surgical, hospital, or ancillary health care expenses of the small  
1459 employer's employees provided as an employee benefit; and

1460 (b) any contract of an insurer, other than a workers' compensation policy, related to the  
1461 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the  
1462 small employer's employees provided as an employee benefit.

1463 (7) The commissioner may make rules requiring that the marketing practices be  
1464 consistent with this chapter for:

- 1465 (a) a small employer carrier;
- 1466 (b) a small employer carrier's agent;
- 1467 (c) an insurance producer; and
- 1468 (d) an insurance consultant.

1469 Section 19. Section **31A-30-106.1** is amended to read:

1470 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

1471 (1) Premium rates for small employer health benefit plans under this chapter are  
1472 subject to the provisions of this section for a health benefit plan that is issued or renewed, on or  
1473 after ~~January 1~~ July 1, 2011.

1474 (2) (a) The index rate for a rating period for any class of business may not exceed the  
1475 index rate for any other class of business by more than 20%.

1476 (b) For a class of business, the premium rates charged during a rating period to covered  
1477 insureds with similar case characteristics for the same or similar coverage, or the rates that  
1478 could be charged to an employer group under the rating system for that class of business, may  
1479 not vary from the index rate by more than 30% of the index rate, except when catastrophic  
1480 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

1481 (3) The percentage increase in the premium rate charged to a covered insured for a new  
1482 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
1483 the following:

- 1484 (a) the percentage change in the new business premium rate measured from the first  
1485 day of the prior rating period to the first day of the new rating period;

1486 (b) any adjustment, not to exceed 15% annually for rating periods of less than one year,  
1487 due to the claim experience, health status, or duration of coverage of the covered individuals as  
1488 determined from the small employer carrier's rate manual for the class of business, except when  
1489 catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d);  
1490 and

1491 (c) any adjustment due to change in coverage or change in the case characteristics of  
1492 the covered insured as determined for the class of business from the small employer carrier's  
1493 rate manual.

1494 (4) (a) Adjustments in rates for claims experience, health status, and duration from  
1495 issue may not be charged to individual employees or dependents.

1496 (b) Rating adjustments and factors, including case characteristics, shall be applied  
1497 uniformly and consistently to the rates charged for all employees and dependents of the small  
1498 employer.

1499 (c) Rating factors shall produce premiums for identical groups that:

1500 (i) differ only by the amounts attributable to plan design; and

1501 (ii) do not reflect differences due to the nature of the groups assumed to select  
1502 particular health benefit products.

1503 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the  
1504 same calendar month as having the same rating period.

1505 (5) A health benefit plan that uses a restricted network provision may not be considered  
1506 similar coverage to a health benefit plan that does not use a restricted network provision,  
1507 provided that use of the restricted network provision results in substantial difference in claims  
1508 costs.

1509 (6) The small employer carrier may not use case characteristics other than the  
1510 following:

1511 (a) age, as determined at the beginning of the plan year, limited to:

1512 (i) the following age bands:

1513 (A) less than 20;

- 1514 (B) 20-24;
- 1515 (C) 25-29;
- 1516 (D) 30-34;
- 1517 (E) 35-39;
- 1518 (F) 40-44;
- 1519 (G) 45-49;
- 1520 (H) 50-54;
- 1521 (I) 55-59;
- 1522 (J) 60-64; and
- 1523 (K) 65 and above; and
- 1524 (ii) a standard slope ratio range for each age band, applied to each family composition
- 1525 tier rating structure under Subsection (6)(c):
- 1526 (A) as developed by the department by administrative rule;
- 1527 (B) not to exceed an overall ratio of 5:1; and
- 1528 (C) the age slope ratios for each age band may not overlap;
- 1529 (b) geographic area; [~~and~~]
- 1530 (c) family composition, limited to:
- 1531 (i) an overall ratio of 5:1 or less; and
- 1532 (ii) a four tier rating structure that includes:
- 1533 (A) employee only;
- 1534 (B) employee plus spouse;
- 1535 (C) employee plus a dependent or dependents; and
- 1536 (D) a family, consisting of an employee plus spouse, and a dependent or dependents;
- 1537 and
- 1538 (d) gender of the employee or spouse.
- 1539 (7) If a health benefit plan is a health benefit plan into which the small employer carrier
- 1540 is no longer enrolling new covered insureds, the small employer carrier shall use the percentage
- 1541 change in the base premium rate, provided that the change does not exceed, on a percentage

1542 basis, the change in the new business premium rate for the most similar health benefit product  
1543 into which the small employer carrier is actively enrolling new covered insureds.

1544 (8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of  
1545 a class of business.

1546 (b) A covered carrier may not offer to transfer a covered insured into or out of a class  
1547 of business unless the offer is made to transfer all covered insureds in the class of business  
1548 without regard to:

- 1549 (i) case characteristics;
- 1550 (ii) claim experience;
- 1551 (iii) health status; or
- 1552 (iv) duration of coverage since issue.

1553 (9) (a) Each small employer carrier shall maintain at the small employer carrier's  
1554 principal place of business a complete and detailed description of its rating practices and  
1555 renewal underwriting practices, including information and documentation that demonstrate that  
1556 the small employer carrier's rating methods and practices are:

- 1557 (i) based upon commonly accepted actuarial assumptions; and
- 1558 (ii) in accordance with sound actuarial principles.

1559 (b) (i) Each small employer carrier shall file with the commissioner on or before April  
1560 1 of each year, in a form and manner and containing information as prescribed by the  
1561 commissioner, an actuarial certification certifying that:

- 1562 (A) the small employer carrier is in compliance with this chapter; and
- 1563 (B) the rating methods of the small employer carrier are actuarially sound.

1564 (ii) A copy of the certification required by Subsection (9)(b)(i) shall be retained by the  
1565 small employer carrier at the small employer carrier's principal place of business.

1566 (c) A small employer carrier shall make the information and documentation described  
1567 in this Subsection (9) available to the commissioner upon request.

1568 (10) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with  
1569 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:



1570 (i) implement this chapter; and  
1571 (ii) assure that rating practices used by small employer carriers under this section and  
1572 carriers for individual plans under Section 31A-30-106, as effective on January 1, 2011, are  
1573 consistent with the purposes of this chapter.

1574 (b) The rules may:  
1575 (i) assure that differences in rates charged for health benefit plans by carriers are  
1576 reasonable and reflect objective differences in plan design, not including differences due to the  
1577 nature of the groups or individuals assumed to select particular health benefit plans; and  
1578 (ii) prescribe the manner in which case characteristics may be used by small employer  
1579 and individual carriers.

1580 (11) Records submitted to the commissioner under this section shall be maintained by  
1581 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
1582 Access and Management Act.

1583 Section 20. Section **31A-30-115** is enacted to read:

1584 **31A-30-115. Actuarial review of health benefit plans.**

1585 (1) (a) The department shall conduct an actuarial review of rates submitted by small  
1586 employer carriers:

1587 (i) prior to the publication of the premium rates on the Health Insurance Exchange;  
1588 (ii) to determine if the rates are in compliance with Subsection 31A-30-202.5(1)(b);  
1589 (iii) to verify the validity of the rates, underwriting and risk factors, and premiums of  
1590 plans both in and outside of the Health Insurance Exchange;

1591 (iv) to verify that insurers are pricing similar health benefit plans and groups the same  
1592 in and out of the exchange; and

1593 (v) as the department determines is necessary to oversee market conduct.

1594 (b) The actuarial review by the department shall be funded from a fee:

1595 (i) established by the department in accordance with Section 63J-1-504; and  
1596 (ii) paid by all small employer carriers participating in the defined contribution  
1597 arrangement market and small employer carriers offering health benefit plans under Chapter

1598 30, Part 1, Individual and Small Employer Group.

1599 (c) The department shall:

1600 (i) report aggregate data from the actuarial review to the risk adjuster board created in  
1601 Section 31A-42-201; and

1602 (ii) contact carriers, if the department determines it is appropriate, to:

1603 (A) inform a carrier of the department's findings regarding the rates of a particular  
1604 carrier; and

1605 (B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

1606 (d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

1607 (2) (a) There is created in the General Fund a restricted account known as the "Health  
1608 Insurance Actuarial Review Restricted Account."

1609 (b) The Health Insurance Actuarial Review Restricted Account shall consist of money  
1610 received by the commissioner under this section.

1611 (c) The commissioner shall administer the Health Insurance Actuarial Review  
1612 Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use  
1613 money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the  
1614 actuarial review conducted by the department under this section.

1615 Section 21. Section **31A-30-203** is amended to read:

1616 **31A-30-203. Eligibility for defined contribution arrangement market --**  
1617 **Enrollment.**

1618 (1) (a) An eligible small employer may choose to participate in:

1619 (i) the defined contribution arrangement market in the Health Insurance Exchange  
1620 under this part; or

1621 (ii) the traditional defined benefit market under Part 1, Individual and Small Employer  
1622 Group.

1623 (b) A small employer may choose to offer its employees one of the following through  
1624 the defined contribution arrangement market in the Health Insurance Exchange:

1625 (i) a defined contribution arrangement health benefit plan; or

1626 (ii) a defined benefit plan.

1627 [~~(c)(i) Beginning January 1, 2011, and during the enrollment period, an eligible large~~  
1628 ~~employer participating in the demonstration project under Subsection 31A-30-208(1)(c) may~~  
1629 ~~choose to offer its employees a defined contribution arrangement health benefit plan.]~~

1630 [~~(ii) Beginning January 1, 2012, an eligible large employer may choose to offer its~~  
1631 ~~employees a defined contribution arrangement health benefit plan.]~~

1632 [~~(d)~~] (c) Defined contribution arrangement health benefit plans are employer group  
1633 health plans individually selected by an employee of an employer.

1634 (2) (a) Participating insurers shall offer to accept all eligible employees of an employer  
1635 described in Subsection (1), and their dependents, at the same level of benefits as anyone else  
1636 who has the same health benefit plan in the defined contribution arrangement market on the  
1637 Health Insurance Exchange.

1638 (b) A participating insurer may:

1639 (i) request an employer to submit a copy of the employer's quarterly wage list to  
1640 determine whether the employees for whom coverage is provided or requested are bona fide  
1641 employees of the employer; and

1642 (ii) deny or terminate coverage if the employer refuses to provide documentation  
1643 requested under Subsection (2)(b)(i).

1644 Section 22. Section **31A-30-205** is amended to read:

1645 **31A-30-205. Health benefit plans offered in the defined contribution market.**

1646 (1) An insurer who offers a defined contribution arrangement health benefit plan in the  
1647 small group market shall offer the following health benefit plans as defined contribution  
1648 arrangements:

1649 [~~(a) the basic benefit plan;~~]

1650 (a) one health benefit plan that:

1651 (i) is a federally qualified high deductible health plan;

1652 (ii) has a deductible that is within \$250 of the lowest deductible that qualifies as a  
1653 federally qualified high deductible health plan as adjusted by federal law; and

1654 (iii) has an annual out-of-pocket maximum that does not exceed three times the amount  
1655 of the deductible;

1656 ~~[(b) one health benefit plan with an aggregate actuarial value at least 15% greater than~~  
1657 ~~the actuarial value of the basic benefit plan;]~~

1658 ~~[(c)]~~ (b) ~~[on or before January 1, 2011,]~~ one health benefit plan that:

1659 (i) is a federally qualified high deductible health plan that ~~[has]~~ is within \$250 of an  
1660 individual deductible of \$2,500 and a deductible of \$5,000 for coverage including two or more  
1661 individuals[-]; and

1662 (ii) does not exceed an annual out-of-pocket maximum equal to three times the amount  
1663 of the annual deductible;

1664 ~~[(d) on or before January 1, 2011,]~~

1665 (c) one health benefit plan that:

1666 (i) is a federally qualified high deductible health plan ~~[that]~~;

1667 (ii) has a deductible that is within ~~[\$250]~~ \$1,000 of the highest deductible that qualifies  
1668 as a federally qualified high deductible health plan, as adjusted by federal law~~[-, and does not~~  
1669 ~~exceed an annual out-of-pocket maximum equal to three times the amount of the annual~~  
1670 ~~deductible]~~; and

1671 (iii) has an out-of-pocket maximum that qualifies as a federally qualified high  
1672 deductible health plan;

1673 ~~[(e)]~~ (d) the insurer's ~~[five]~~ four most commonly selected small group health benefit  
1674 plans that:

1675 (i) include:

1676 (A) the provider panel;

1677 (B) the deductible;

1678 (C) co-payments;

1679 (D) co-insurance; and

1680 (E) pharmacy benefits; ~~[and]~~

1681 (ii) are currently being marketed by the carrier to new groups for enrollment[-]; and

1682 (iii) meet the standard for most commonly selected plan as determined by  
 1683 administrative rule adopted by the commissioner; and

1684 (e) alternative coverage required by Section 31A-22-724.

1685 (2) (a) The provisions of Subsection (1) do not limit the number of defined  
 1686 contribution arrangement health benefit plans an insurer may offer in the defined contribution  
 1687 arrangement market.

1688 (b) An insurer who offers the health benefit plans required by Subsection (1) may also  
 1689 offer any other health benefit plan as a defined contribution arrangement if[: (i) the health  
 1690 benefit plan provides benefits that are of greater actuarial value than the benefits required in the  
 1691 basic benefit plan; or (ii)] the health benefit plan provides benefits with an aggregate actuarial  
 1692 value that is no lower than the actuarial value of the plan required in Subsection (1)(c).

1693 (3) An employee who has the right to extend employer coverage under Subsection  
 1694 31A-22-722(1) or federal COBRA, may:

1695 (a) continue coverage under the employee's current plan under state mini-COBRA or  
 1696 federal COBRA; or

1697 (b) enroll in alternative coverage under Section 31A-22-724.

1698 Section 23. Section **31A-30-207** is amended to read:

1699 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**  
 1700 **contribution arrangement market.**

1701 (1) The rating and underwriting restrictions for defined benefit plans and for the  
 1702 defined contribution arrangement health benefit plans offered in the Health Insurance  
 1703 Exchange defined contribution arrangement market shall be[: (a) for small employer groups,]  
 1704 in accordance with Section 31A-30-106.1[: (b) for large employer groups, as determined by  
 1705 the risk adjuster board for participation in the risk adjustment mechanism under Chapter 42,  
 1706 ~~Defined Contribution Risk Adjuster Act; and (c) established in accordance with], and the plan  
 1707 adopted under Chapter 42, Defined Contribution Risk Adjuster Act.~~

1708 (2) All insurers who participate in the defined contribution market shall:

1709 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined

1710 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

1711 (b) provide the risk adjuster board with:

1712 (i) an employer group's risk factor; and

1713 (ii) carrier enrollment data; and

1714 (c) submit rates to the exchange that are net of commissions.

1715 (3) When an employer group ~~[of any size]~~ enters the defined contribution arrangement

1716 market for either a defined contribution arrangement health benefit plan, or a defined benefit

1717 plan, and the employer group has a health plan with an insurer who is participating in the

1718 defined contribution arrangement market, the risk factor applied to the employer group when it

1719 enters the defined contribution market may not be greater than the employer group's renewal

1720 risk factor for the same group of covered employees and the same effective date, as determined

1721 by the employer group's insurer.

1722 Section 24. Section **31A-30-208** is amended to read:

1723 **31A-30-208. Enrollment for defined contribution arrangements.**

1724 (1) An insurer offering a health benefit plan in the defined contribution arrangement

1725 market:

1726 (a) ~~[beginning on or after January 1, 2011,]~~ shall allow an employer to enroll in a small

1727 employer defined contribution arrangement plan;

1728 (b) may not impose a surcharge under Section 31A-30-106.7 for a small employer

1729 group selecting a defined contribution arrangement health benefit plan on or before January 1,

1730 2012; and

1731 ~~[(c) shall offer a limited pilot program in which a large employer group may enroll in a~~

1732 ~~defined contribution arrangement market plan that takes effect January 1, 2011;]~~

1733 ~~[(d) beginning January 1, 2012, shall allow a large employer group to enroll in the~~

1734 ~~defined contribution arrangement market, and]~~

1735 ~~[(e)]~~ (c) shall otherwise comply with the requirements of this part, Chapter 42, Defined

1736 Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

1737 (2) (a) Except as provided in Subsection 31A-30-202.5(2), in accordance with

1738 Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined  
1739 contribution arrangement market.

1740 (b) An insurer may offer new or modify existing products in the defined contribution  
1741 arrangement market:

1742 (i) on January 1 of each year;

1743 (ii) when required by changes in other law; and

1744 (iii) at other times as established by the risk adjuster board created in Section  
1745 31A-42-201.

1746 (c) (i) An insurer shall give the department, the Health Insurance Exchange, and the  
1747 risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a)  
1748 or (b).

1749 (ii) When an insurer elects to participate in the defined contribution arrangement  
1750 market, the insurer shall participate in the defined contribution arrangement market for no less  
1751 than two years.

1752 Section 25. Section **31A-30-209** is amended to read:

1753 **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**

1754 (1) A producer may be listed on the Health Insurance Exchange as a producer for the  
1755 defined contribution arrangement market in accordance with Section 63M-1-2504, if the  
1756 producer is designated as an appointed agent for the defined contribution arrangement market  
1757 in accordance with Subsection (2).

1758 (2) A producer whose license under this title authorizes the producer to sell defined  
1759 contribution arrangement health benefit plans may be appointed to the defined contribution  
1760 arrangement market on the Health Insurance Exchange by the Insurance Department and may  
1761 sell any product on the Health Insurance Exchange, if the producer:

1762 (a) submits an application to the Insurance Department to be appointed as a producer  
1763 for the defined contribution arrangement market on the Health Insurance Exchange;

1764 (b) is an appointed agent in accordance with Subsection (3), for products offered in the  
1765 defined contribution arrangement market of the Health Insurance Exchange, with the [majority

1766 ~~of the~~] carriers that offer a defined contribution arrangement health benefit plan on the Health  
1767 Insurance Exchange; and

1768 (c) has completed [a] continuing education for the defined contribution arrangement  
1769 ~~[training session that is an approved training session as designated by the commissioner.]~~  
1770 market that:

1771 (i) is required by administrative rule adopted by the commissioner; and

1772 (ii) provides training on premium assistance programs.

1773 (3) A carrier shall appoint a producer to sell the carrier's products in the defined  
1774 contribution arrangement market of the Health Insurance Exchange, within 30 days of the  
1775 notice required in Subsection (3)(b), if:

1776 (a) the producer is currently appointed by a majority of the carriers in the Health  
1777 Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange;  
1778 and

1779 (b) the producer informs the carrier that the producer is:

1780 (i) applying to be appointed to the defined contribution arrangement market in the  
1781 Health Insurance Exchange;

1782 (ii) appointed by a majority of the carriers in the defined contribution arrangement  
1783 market in the Health Insurance Exchange;

1784 (iii) willing to complete training regarding the carrier's products offered on the defined  
1785 contribution arrangement market in the Health Insurance Exchange; and

1786 (iv) willing to sign the contracts and business associate's agreements that the carrier  
1787 requires for appointed producers in the Health Insurance Exchange.

1788 Section 26. Section **31A-30-211** is enacted to read:

1789 **31A-30-211. Insurer disclosure.**

1790 (1) The Health Insurance Exchange shall provide an employer and an employer's  
1791 producer with the group's risk factor used to calculate the employer group's premium at the  
1792 time of:

1793 (a) the initial offering of a health benefit plan; and



- 1794 (b) the renewal of a health benefit plan.
- 1795 (2) For health benefit plans that renew on or after March 1, 2012:
- 1796 (a) a carrier in the small employer market under Part 1, Individual and Small Employer
- 1797 Group, shall provide an employer and the employer's producer with premium renewal rates at
- 1798 least 60 days prior to the group's renewal date; and
- 1799 (b) the Health Insurance Exchange shall provide an employer who is participating in
- 1800 the defined contribution arrangement market of the Health Insurance Exchange and the
- 1801 employer's producer with premium renewal rates at least 60 days prior to a group's renewal.

1802 Section 27. Section **31A-42-202** is amended to read:

1803 **31A-42-202. Contents of plan.**

- 1804 (1) The board shall submit a plan of operation for the risk adjuster to the
- 1805 commissioner. The plan shall:
  - 1806 (a) establish the methodology for implementing:
    - 1807 (i) Subsection (2) for the defined contribution arrangement market established under
    - 1808 Chapter 30, Part 2, Defined Contribution Arrangements; and
    - 1809 (ii) the participation of~~[-(A)]~~ small employer group defined contribution arrangement
    - 1810 health benefit plans; ~~[and]~~
    - 1811 ~~[(B) large employer group defined contribution arrangement health benefit plans;]~~
  - 1812 (b) establish regular times and places for meetings of the board;
  - 1813 (c) establish procedures for keeping records of all financial transactions and for
  - 1814 sending annual fiscal reports to the commissioner;
  - 1815 (d) contain additional provisions necessary and proper for the execution of the powers
  - 1816 and duties of the risk adjuster; and
  - 1817 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
  - 1818 Code, to pay for administrative expenses incurred.
- 1819 (2) (a) The plan adopted by the board for the defined contribution arrangement market
- 1820 shall include:
  - 1821 (i) parameters an employer may use to designate eligible employees for the defined

1822 contribution arrangement market; and  
1823           (ii) underwriting mechanisms and employer eligibility guidelines:  
1824           (A) consistent with the federal Health Insurance Portability and Accountability Act;  
1825 and  
1826           (B) necessary to protect insurance carriers from adverse selection in the defined  
1827 contribution market.  
1828           (b) The plan required by Subsection (2)(a) shall outline how premium rates for a  
1829 qualified individual are determined, including:  
1830           (i) the identification of an initial rate for a qualified individual based on:  
1831           (A) standardized age bands submitted by participating insurers; and  
1832           (B) wellness incentives for the individual as permitted by federal law; and  
1833           (ii) the identification of a group risk factor to be applied to the initial age rate of a  
1834 qualified individual based on the health conditions of all qualified individuals in the same  
1835 employer group and, for small employers, in accordance with Sections 31A-30-105 and  
1836 31A-30-106.1.  
1837           (c) The plan adopted under Subsection (2)(a) shall outline how:  
1838           (i) premium contributions for qualified individuals shall be submitted to the Health  
1839 Insurance Exchange in the amount determined under Subsection (2)(b); and  
1840           (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by  
1841 qualified individuals within an employer group based on each individual's rating factor  
1842 determined in accordance with the plan.  
1843           (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting  
1844 risk between insurers that:  
1845           (i) identifies health care conditions subject to risk adjustment;  
1846           (ii) establishes an adjustment amount for each identified health care condition;  
1847           (iii) determines the extent to which an insurer has more or less individuals with an  
1848 identified health condition than would be expected; and  
1849           (iv) computes all risk adjustments.

1850 (e) The board may amend the plan if necessary to:

1851 ~~[(i) incorporate large group defined contribution arrangement health benefit plans into~~

1852 ~~the defined contribution arrangement market risk adjuster mechanism created by this chapter;]~~

1853 ~~[(ii)] (i) maintain the proper functioning and solvency of the defined contribution~~

1854 ~~arrangement market and the risk adjuster mechanism;~~

1855 ~~[(iii)] (ii) mitigate significant issues of risk selection; or~~

1856 ~~[(iv)] (iii) improve the administration of the risk adjuster mechanism [including~~

1857 ~~opening enrollment periodically until January 1, 2011, for the purpose of testing the enrollment~~

1858 ~~and risk adjusting process].~~

1859 (3) ~~[(a)]~~ The board shall establish a mechanism in which the participating carriers shall

1860 submit their plan base rates, rating factors, and premiums to ~~[an independent actuary, appointed~~

1861 ~~by the board, for review prior to the publication of the premium rates on the Health Insurance~~

1862 ~~Exchange] the commissioner for an actuarial review under the provisions of Section~~

1863 ~~31A-30-115 prior to the publication of the premium rates on the Health Insurance Exchange.~~

1864 ~~[(b) The actuary appointed by the board shall:]~~

1865 ~~[(i) be compensated for the analysis under this section from fees established in~~

1866 ~~accordance with Section 63J-1-504:]~~

1867 ~~[(A) assessed by the board; and]~~

1868 ~~[(B) paid by all small employer carriers participating in the defined contribution~~

1869 ~~arrangement market and small employer carriers offering health benefit plans under Chapter~~

1870 ~~30, Part 1, Individual and Small Employer Group; and]~~

1871 ~~[(ii) review the information submitted:]~~

1872 ~~[(A) under Subsection (3)(a) for the purpose of verifying the validity of the rates, rating~~

1873 ~~factors, and premiums; and]~~

1874 ~~[(B) from carriers offering health benefit plans under Chapter 30, Part 1, Individual and~~

1875 ~~Small Employer Group:]~~

1876 ~~[(i) for the purpose of verifying underwriting and rating practices; and]~~

1877 ~~[(ii) as the actuary determines is necessary.]~~

1878 ~~[(c) Fees collected under Subsection (3)(b) shall be used to pay the actuary for the~~  
 1879 ~~purpose of overseeing market conduct.]~~

1880 ~~[(d) The actuary shall:]~~

1881 ~~[(i) report aggregate data to the risk adjuster board;]~~

1882 ~~[(ii) contact carriers:]~~

1883 ~~[(A) to inform a carrier of the actuary's findings regarding the particular carrier; and]~~

1884 ~~[(B) to request a carrier to re-calculate or verify base rates, rating factors, and~~  
 1885 ~~premiums; and]~~

1886 ~~[(iii) share the actuary's analysis and data with the department for the purposes~~  
 1887 ~~described in Section 31A-30-106.1.]~~

1888 ~~[(e) A carrier shall re-submit premium rates if the department contacts the carrier under~~  
 1889 ~~Subsection (3).]~~

1890 Section 28. Section **63A-5-205** is amended to read:

1891 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**  
 1892 **coverage.**

1893 (1) As used in this section:

1894 (a) "Capital developments" has the same meaning as provided in Section 63A-5-104.

1895 (b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.

1896 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section  
 1897 34A-2-104 who:

1898 (i) works at least 30 hours per calendar week; and

1899 (ii) meets employer eligibility waiting requirements for health care insurance which  
 1900 may not exceed the first day of the calendar month following 90 days from the date of hire.

1901 (d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

1902 (e) "Qualified health insurance coverage" ~~[means at the time the contract is entered into~~  
 1903 ~~or renewed:]~~ is as defined in Section 26-40-115.

1904 ~~[(i) a health benefit plan and employer contribution level with a combined actuarial~~  
 1905 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~

1906 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~  
1907 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~  
1908 ~~employee who reside or work in the state, in which:]~~

1909 ~~[(A) the employer pays at least 50% of the premium for the employee and the~~  
1910 ~~dependents of the employee who reside or work in the state; and]~~

1911 ~~[(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]~~

1912 ~~[(F) rather than the benchmark plan's deductible, and the benchmark plan's~~  
1913 ~~out-of-pocket maximum based on income levels:]~~

1914 ~~[(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

1915 ~~[(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]~~

1916 ~~[(H) dental coverage is not required; and]~~

1917 ~~[(HH) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~  
1918 ~~not apply; or]~~

1919 ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~  
1920 ~~deductible that is either:]~~

1921 ~~[(F) the lowest deductible permitted for a federally qualified high deductible health~~  
1922 ~~plan; or]~~

1923 ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~  
1924 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~  
1925 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~  
1926 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~  
1927 ~~employer offered federally qualified high deductible plan;]~~

1928 ~~[(B) an out-of-pocket maximum that does not exceed three times the amount of the~~  
1929 ~~annual deductible; and]~~

1930 ~~[(C) under which the employer pays 75% of the premium for the employee and the~~  
1931 ~~dependents of the employee who work or reside in the state.]~~

1932 (f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

1933 (2) In accordance with Title 63G, Chapter 6, Utah Procurement Code, the director may:

1934 (a) subject to Subsection (3), enter into contracts for any work or professional services  
1935 which the division or the State Building Board may do or have done; and

1936 (b) as a condition of any contract for architectural or engineering services, prohibit the  
1937 architect or engineer from retaining a sales or agent engineer for the necessary design work.

1938 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design  
1939 or construction contracts entered into by the division or the State Building Board on or after  
1940 July 1, 2009, and:

1941 (i) applies to a prime contractor if the prime contract is in the amount of \$1,500,000 or  
1942 greater; and

1943 (ii) applies to a subcontractor if the subcontract is in the amount of \$750,000 or greater.

1944 (b) This Subsection (3) does not apply:

1945 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

1946 (ii) if the contract is a sole source contract;

1947 (iii) if the contract is an emergency procurement; or

1948 (iv) to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification  
1949 to a contract, when the contract does not meet the threshold required by Subsection (3)(a).

1950 (c) A person who intentionally uses change orders or contract modifications to  
1951 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

1952 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that  
1953 the contractor has and will maintain an offer of qualified health insurance coverage for the  
1954 contractor's employees and the employees' dependents.

1955 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor  
1956 shall demonstrate to the director that the subcontractor has and will maintain an offer of  
1957 qualified health insurance coverage for the subcontractor's employees and the employees'  
1958 dependents.

1959 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)  
1960 during the duration of the contract is subject to penalties in accordance with administrative  
1961 rules adopted by the division under Subsection (3)(f).

1962 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
1963 requirements of Subsection (3)(d)(ii).

1964 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)  
1965 during the duration of the contract is subject to penalties in accordance with administrative  
1966 rules adopted by the division under Subsection (3)(f).

1967 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
1968 requirements of Subsection (3)(d)(i).

1969 (f) The division shall adopt administrative rules:

1970 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1971 (ii) in coordination with:

1972 (A) the Department of Environmental Quality in accordance with Section 19-1-206;

1973 (B) the Department of Natural Resources in accordance with Section 79-2-404;

1974 (C) a public transit district in accordance with Section 17B-2a-818.5;

1975 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

1976 (E) the Department of Transportation in accordance with Section 72-6-107.5; and

1977 (F) the Legislature's Administrative Rules Review Committee; and

1978 (iii) which establish:

1979 (A) the requirements and procedures a contractor must follow to demonstrate to the  
1980 director compliance with this Subsection (3) which shall include:

1981 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)  
1982 or (ii) more than twice in any 12-month period; and

1983 (II) that the actuarially equivalent determination required for the qualified health  
1984 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the  
1985 department or division with a written statement of actuarial equivalency from either:

1986 (Aa) the Utah Insurance Department;

1987 (Bb) an actuary selected by the contractor or the contractor's insurer; or

1988 (Cc) an underwriter who is responsible for developing the employer group's premium  
1989 rates;

1990 (B) the penalties that may be imposed if a contractor or subcontractor intentionally  
1991 violates the provisions of this Subsection (3), which may include:

1992 (I) a three-month suspension of the contractor or subcontractor from entering into  
1993 future contracts with the state upon the first violation;

1994 (II) a six-month suspension of the contractor or subcontractor from entering into future  
1995 contracts with the state upon the second violation;

1996 (III) an action for debarment of the contractor or subcontractor in accordance with  
1997 Section 63G-6-804 upon the third or subsequent violation; and

1998 (IV) monetary penalties which may not exceed 50% of the amount necessary to  
1999 purchase qualified health insurance coverage for an employee and the dependents of an  
2000 employee of the contractor or subcontractor who was not offered qualified health insurance  
2001 coverage during the duration of the contract; and

2002 (C) a website on which the department shall post the benchmark for the qualified  
2003 health insurance coverage identified in Subsection (1)(e)[(†)].

2004 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or  
2005 subcontractor who intentionally violates the provisions of this section shall be liable to the  
2006 employee for health care costs that would have been covered by qualified health insurance  
2007 coverage.

2008 (ii) An employer has an affirmative defense to a cause of action under Subsection  
2009 (3)(g)(i) if:

2010 (A) the employer relied in good faith on a written statement of actuarial equivalency  
2011 provided by:

2012 (I) an actuary; or

2013 (II) an underwriter who is responsible for developing the employer group's premium  
2014 rates; or

2015 (B) the department determines that compliance with this section is not required under  
2016 the provisions of Subsection (3)(b).

2017 (iii) An employee has a private right of action only against the employee's employer to



2018 enforce the provisions of this Subsection (3)(g).

2019 (h) Any penalties imposed and collected under this section shall be deposited into the  
2020 Medicaid Restricted Account created by Section 26-18-402.

2021 (i) The failure of a contractor or subcontractor to provide qualified health insurance  
2022 coverage as required by this section:

2023 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,  
2024 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,  
2025 Legal and Contractual Remedies; and

2026 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or  
2027 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
2028 or construction.

2029 (4) The judgment of the director as to the responsibility and qualifications of a bidder  
2030 is conclusive, except in case of fraud or bad faith.

2031 (5) The division shall make all payments to the contractor for completed work in  
2032 accordance with the contract and pay the interest specified in the contract on any payments that  
2033 are late.

2034 (6) If any payment on a contract with a private contractor to do work for the division or  
2035 the State Building Board is retained or withheld, it shall be retained or withheld and released as  
2036 provided in Section 13-8-5.

2037 Section 29. Section **63C-9-403** is amended to read:

2038 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

2039 (1) For purposes of this section:

2040 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
2041 34A-2-104 who:

2042 (i) works at least 30 hours per calendar week; and

2043 (ii) meets employer eligibility waiting requirements for health care insurance which  
2044 may not exceed the first of the calendar month following 90 days from the date of hire.

2045 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2046 (c) "Qualified health insurance coverage" [means at the time the contract is entered into  
2047 or renewed:] is as defined in Section 26-40-115.

2048 [(i) a health benefit plan and employer contribution level with a combined actuarial  
2049 value at least actuarially equivalent to the combined actuarial value of the benchmark plan  
2050 determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and  
2051 a contribution level of 50% of the premium for the employee and the dependents of the  
2052 employee who reside or work in the state, in which:]

2053 [(A) the employer pays at least 50% of the premium for the employee and the  
2054 dependents of the employee who reside or work in the state; and]

2055 [(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]

2056 [(F) rather than the benchmark plan's deductible, and the benchmark plan's  
2057 out-of-pocket maximum based on income levels:]

2058 [(Aa) the deductible is \$750 per individual and \$2,250 per family; and]

2059 [(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]

2060 [(H) dental coverage is not required; and]

2061 [(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do  
2062 not apply; or]

2063 [(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a  
2064 deductible that is either:]

2065 [(F) the lowest deductible permitted for a federally qualified high deductible health  
2066 plan; or]

2067 [(H) a deductible that is higher than the lowest deductible permitted for a federally  
2068 qualified high deductible health plan, but includes an employer contribution to a health savings  
2069 account in a dollar amount at least equal to the dollar amount difference between the lowest  
2070 deductible permitted for a federally qualified high deductible plan and the deductible for the  
2071 employer offered federally qualified high deductible plan;]

2072 [(B) an out-of-pocket maximum that does not exceed three times the amount of the  
2073 annual deductible; and]

2074            [~~(C) under which the employer pays 75% of the premium for the employee and the~~  
2075 ~~dependents of the employee who work or reside in the state.]~~

2076            (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2077            (2) (a) Except as provided in Subsection (3), this section applies to a design or  
2078 construction contract entered into by the board or on behalf of the board on or after July 1,  
2079 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).

2080            (b) (i) A prime contractor is subject to this section if the prime contract is in the  
2081 amount of \$1,500,000 or greater.

2082            (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
2083 \$750,000 or greater.

2084            (3) This section does not apply if:

2085            (a) the application of this section jeopardizes the receipt of federal funds;

2086            (b) the contract is a sole source contract; or

2087            (c) the contract is an emergency procurement.

2088            (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]  
2089 63G-6-103, or a modification to a contract, when the contract does not meet the initial  
2090 threshold required by Subsection (2).

2091            (b) A person who intentionally uses change orders or contract modifications to  
2092 circumvent the requirements of Subsection (2) is guilty of an infraction.

2093            (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive  
2094 director that the contractor has and will maintain an offer of qualified health insurance  
2095 coverage for the contractor's employees and the employees' dependents during the duration of  
2096 the contract.

2097            (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor  
2098 shall demonstrate to the executive director that the subcontractor has and will maintain an offer  
2099 of qualified health insurance coverage for the subcontractor's employees and the employees'  
2100 dependents during the duration of the contract.

2101            (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during

2102 the duration of the contract is subject to penalties in accordance with administrative rules  
2103 adopted by the division under Subsection (6).

2104 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
2105 requirements of Subsection (5)(b).

2106 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
2107 the duration of the contract is subject to penalties in accordance with administrative rules  
2108 adopted by the department under Subsection (6).

2109 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
2110 requirements of Subsection (5)(a).

2111 (6) The department shall adopt administrative rules:

2112 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2113 (b) in coordination with:

2114 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2115 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

2116 (iii) the State Building Board in accordance with Section 63A-5-205;

2117 (iv) a public transit district in accordance with Section 17B-2a-818.5;

2118 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

2119 (vi) the Legislature's Administrative Rules Review Committee; and

2120 (c) which establish:

2121 (i) the requirements and procedures a contractor must follow to demonstrate to the  
2122 executive director compliance with this section which shall include:

2123 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

2124 (b) more than twice in any 12-month period; and

2125 (B) that the actuarially equivalent determination required for the qualified health  
2126 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the  
2127 department or division with a written statement of actuarial equivalency from either:

2128 (I) the Utah Insurance Department;

2129 (II) an actuary selected by the contractor or the contractor's insurer; or

2130 (III) an underwriter who is responsible for developing the employer group's premium  
2131 rates;

2132 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
2133 violates the provisions of this section, which may include:

2134 (A) a three-month suspension of the contractor or subcontractor from entering into  
2135 future contracts with the state upon the first violation;

2136 (B) a six-month suspension of the contractor or subcontractor from entering into future  
2137 contracts with the state upon the second violation;

2138 (C) an action for debarment of the contractor or subcontractor in accordance with  
2139 Section 63G-6-804 upon the third or subsequent violation; and

2140 (D) monetary penalties which may not exceed 50% of the amount necessary to  
2141 purchase qualified health insurance coverage for employees and dependents of employees of  
2142 the contractor or subcontractor who were not offered qualified health insurance coverage  
2143 during the duration of the contract; and

2144 (iii) a website on which the department shall post the benchmark for the qualified  
2145 health insurance coverage identified in Subsection (1)(c)[(†)].

2146 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or  
2147 subcontractor who intentionally violates the provisions of this section shall be liable to the  
2148 employee for health care costs that would have been covered by qualified health insurance  
2149 coverage.

2150 (ii) An employer has an affirmative defense to a cause of action under Subsection  
2151 (7)(a)(i) if:

2152 (A) the employer relied in good faith on a written statement of actuarial equivalency  
2153 provided by:

2154 (I) an actuary; or

2155 (II) an underwriter who is responsible for developing the employer group's premium  
2156 rates; or

2157 (B) the department determines that compliance with this section is not required under

2158 the provisions of Subsection (3) or (4).

2159 (b) An employee has a private right of action only against the employee's employer to  
2160 enforce the provisions of this Subsection (7).

2161 (8) Any penalties imposed and collected under this section shall be deposited into the  
2162 Medicaid Restricted Account created in Section 26-18-402.

2163 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
2164 coverage as required by this section:

2165 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
2166 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,  
2167 Legal and Contractual Remedies; and

2168 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
2169 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
2170 or construction.

2171 Section 30. Section **63I-1-231** is amended to read:

2172 **63I-1-231. Repeal dates, Title 31A.**

2173 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.

2174 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.

2175 (3) Section 31A-22-625, Catastrophic coverage of mental health conditions, is repealed  
2176 July 1, 2011.

2177 [~~4) Chapter 42a, Utah Statewide Risk Adjuster Act, is repealed July 1, 2016.~~]

2178 Section 31. Section **63J-1-602.2** is amended to read:

2179 **63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.**

2180 (1) Appropriations from the Technology Development Restricted Account created in  
2181 Section 31A-3-104.

2182 (2) Appropriations from the Criminal Background Check Restricted Account created in  
2183 Section 31A-3-105.

2184 (3) Appropriations from the Captive Insurance Restricted Account created in Section  
2185 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that

2186 section free revenue.

2187 (4) Appropriations from the Title Licensee Enforcement Restricted Account created in  
2188 Section 31A-23a-415.

2189 (5) The fund for operating the state's Federal Health Care Tax Credit Program, as  
2190 provided in Section 31A-38-104.

2191 (6) Appropriations from the Health Insurance Actuarial Review Restricted Account  
2192 created in Section 31A-30-115.

2193 [~~(6)~~] (7) The Special Administrative Expense Account created in Section 35A-4-506.

2194 [~~(7)~~] (8) Funding for a new program or agency that is designated as nonlapsing under  
2195 Section 36-24-101.

2196 [~~(8)~~] (9) The Oil and Gas Conservation Account created in Section 40-6-14.5.

2197 [~~(9)~~] (10) The Off-Highway Access and Education Restricted Account created in  
2198 Section 41-22-19.5.

2199 Section 32. Section **63M-1-2504** is amended to read:

2200 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**

2201 (1) There is created within the Governor's Office of Economic Development the Office  
2202 of Consumer Health Services.

2203 (2) The office shall:

2204 (a) in cooperation with the Insurance Department, the Department of Health, and the  
2205 Department of Workforce Services, and in accordance with the electronic standards developed  
2206 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:

2207 [~~(i) is capable of providing access to private and government health insurance websites~~  
2208 ~~and their electronic application forms and submission procedures;]~~

2209 (i) provides information to consumers about private and public health programs for  
2210 which the consumer may qualify;

2211 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted  
2212 on the Health Insurance Exchange [~~by an insurer for the~~]; and

2213 [~~(A) small employer group market;~~]

2214 ~~[(B) the individual market; and]~~  
2215 ~~[(C) the defined contribution arrangement market; and]~~  
2216 (iii) includes information and a link to enrollment in premium assistance programs and  
2217 other government assistance programs;  
2218 (b) ~~[facilitate a private sector method]~~ contract with one or more private vendors for:  
2219 (i) administration of the enrollment process on the Health Insurance Exchange,  
2220 including establishing a mechanism for consumers to compare health benefit plan features on  
2221 the exchange and filter the plans based on consumer preferences;  
2222 (ii) the collection of health insurance premium payments made for a single policy by  
2223 multiple payers, including the policyholder, one or more employers of one or more individuals  
2224 covered by the policy, government programs, and others [by educating employers and insurers  
2225 about collection services available through private vendors, including financial institutions];  
2226 and  
2227 (iii) establishing a call center in accordance with Subsection (3);  
2228 (c) assist employers with a free or low cost method for establishing mechanisms for the  
2229 purchase of health insurance by employees using pre-tax dollars;  
2230 ~~[(d) periodically convene health care providers, payers, and consumers to monitor the~~  
2231 ~~progress being made regarding demonstration projects for health care delivery and payment~~  
2232 ~~reform;]~~  
2233 ~~[(e)]~~ (d) establish a list on the Health Insurance Exchange of insurance producers who,  
2234 in accordance with Section 31A-30-209, are appointed producers for the ~~[defined contribution~~  
2235 ~~arrangement market on the]~~ Health Insurance Exchange; and  
2236 ~~[(f)]~~ (e) report to the Business and Labor Interim Committee and the Health System  
2237 Reform Task Force prior to November 1, ~~[2010]~~ 2011, and prior to the Legislative interim day  
2238 in November of each year thereafter regarding~~[-(i)]~~ the operations of the Health Insurance  
2239 Exchange required by this chapter~~[-and]~~.  
2240 ~~[(ii) the progress of the demonstration projects for health care payment and delivery~~  
2241 ~~reform.]~~



2242           (3) A call center established by the office:  
2243           (a) shall provide unbiased answers to questions concerning exchange operations, and  
2244 plan information, to the extent the plan information is posted on the exchange by the insurer;  
2245 and  
2246           (b) may not:  
2247           (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;  
2248           (ii) beginning July 1, 2011, receive producer compensation through the Health  
2249 Insurance Exchange; and  
2250           (iii) beginning July 1, 2011, be designated as the default producer for an employer  
2251 group that enters the Health Insurance Exchange without a producer.  
2252           ~~[(3)]~~ (4) The office:  
2253           (a) may not:  
2254           (i) regulate health insurers, health insurance plans, ~~or~~ health insurance producers, or  
2255 health insurance premiums charged in the exchange;  
2256           (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or  
2257           (iii) act as an appeals entity for resolving disputes between a health insurer and an  
2258 insured; ~~and~~  
2259           (b) may establish and collect a fee in accordance with Section 63J-1-504 for:  
2260           (i) the transaction cost of:  
2261           ~~[(i)]~~ (A) processing an application for a health benefit plan ~~[from the Internet portal to~~  
2262 ~~an insurer; and]~~;  
2263           ~~[(ii)]~~ (B) accepting, processing, and submitting multiple premium payment sources~~[-]~~;  
2264 and  
2265           (C) providing a mechanism for consumers to filter and compare health benefit plans in  
2266 the exchange based on consumer preferences; and  
2267           (ii) funding the call center established in accordance with Subsection (3); and  
2268           (c) shall separately itemize any fees established under Subsection (4)(b) as part of the  
2269 cost displayed for the employer selecting coverage on the exchange.

2270 Section 33. Section **63M-1-2506** is amended to read:

2271 **63M-1-2506. Health benefit plan information on Health Insurance Exchange --**  
2272 **Insurer transparency.**

2273 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,  
2274 Chapter 3, Utah Administrative Rulemaking Act, ~~[that:]~~ that establish uniform electronic  
2275 standards for insurers, employers, brokers, consumers, and vendors to use when transmitting or  
2276 receiving information, uniform applications, waivers of coverage, or payments to, or from, the  
2277 Health Insurance Exchange.

2278 ~~[(i) establish uniform electronic standards for:]~~

2279 ~~[(A) a health insurer to use when:]~~

2280 ~~[(F) transmitting information to:]~~

2281 ~~[(Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and]~~

2282 ~~[(Bb) the Health Insurance Exchange as required by this section;]~~

2283 ~~[(H) receiving information from the Health Insurance Exchange;]~~

2284 ~~[(Hh) receiving or transmitting the universal health application to or from the Health~~  
2285 ~~Insurance Exchange;]~~

2286 ~~[(B) facilitating the transmission and receipt of premium payments from multiple~~  
2287 ~~sources in the defined contribution arrangement market; and]~~

2288 ~~[(C) the use of the uniform health insurance application required by Section~~  
2289 ~~31A-22-635 on the Health Insurance Exchange;]~~

2290 ~~[(ii) designate the level of detail that would be helpful for a concise consumer~~  
2291 ~~comparison of the items described in Subsections (4) and (5) on the Health Insurance~~  
2292 ~~Exchange;]~~

2293 (b) The administrative rules adopted by the office shall:

2294 (i) promote an efficient and consumer friendly process for shopping for and enrolling  
2295 in a health benefit plan offered on the Health Insurance Exchange; and

2296 (ii) if appropriate, as determined by the office, comply with standards adopted at the  
2297 national level.

2298            ~~[(iii)]~~ (2) The office shall assist the risk adjuster board created under Title 31A,  
 2299 Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined  
 2300 contribution market on the Health Insurance Exchange with the determination of when an  
 2301 employer is eligible to participate in the Health Insurance Exchange under Title 31A, Chapter  
 2302 30, Part 2, Defined Contribution Arrangements~~;~~and].

2303            ~~[(iv)]~~ (3) (a) The office shall create an advisory board to advise the exchange  
 2304 concerning the operation of the exchange, the consumer experience on the exchange, and  
 2305 transparency issues ~~[with]~~].

2306            (b) The advisory board shall have the following members:

2307            ~~[(A)]~~ (i) two health producers who are ~~[registered]~~ appointed producers with the Health  
 2308 Insurance Exchange;

2309            ~~[(B) two consumers;]~~

2310            ~~[(C) one representative from a large insurer who participates on the exchange;]~~

2311            ~~[(D) one representative from a small insurer who participates on the exchange;]~~

2312            (ii) two representatives from community-based, non-profit organizations;

2313            (iii) one representative from an employer that participates in the defined contribution  
 2314 market on the Health Insurance Exchange;

2315            (iv) up to four representatives from insurers who participate in the defined contribution  
 2316 market of the Health Insurance Exchange;

2317            ~~[(E)]~~ (v) one representative from the Insurance Department; and

2318            ~~[(F)]~~ (vi) one representative from the Department of Health.

2319            (c) Members of the advisory board shall serve without compensation.

2320            ~~[(b)]~~ (4) The office shall post or facilitate the posting, on the Health Insurance  
 2321 Exchange, ~~of~~~~[(i)]~~ the information required by this section ~~[on the Health Insurance Exchange~~  
 2322 ~~created by this part; and (ii)]~~ and Section 31A-22-635 and links to websites that provide cost  
 2323 and quality information from the Department of Health Data Committee or neutral entities with  
 2324 a broad base of support from the provider and payer communities.

2325            ~~[(2) A health insurer shall use the uniform electronic standards when transmitting~~

2326 information to the Health Insurance Exchange or receiving information from the Health  
2327 Insurance Exchange.]

2328       ~~[(3) (a) (i) An insurer who participates in the defined contribution arrangement market~~  
2329 ~~under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans~~  
2330 ~~offered in the defined contribution arrangement market on the Health Insurance Exchange and~~  
2331 ~~shall comply with the provisions of this section.]~~

2332       ~~[(ii) Beginning January 1, 2013, an insurer who offers a health benefit plan to a small~~  
2333 ~~employer group in the state shall:]~~

2334       ~~[(A) post the health benefit plans in which the insurer is enrolling new groups on the~~  
2335 ~~Health Insurance Exchange; and]~~

2336       ~~[(B) comply with the provisions of this section:]~~

2337       ~~[(b) An insurer who offers individual health benefit plans under Title 31A, Chapter 30,~~  
2338 ~~Part 1, Individual and Small Employer Group:]~~

2339       ~~[(i) shall post on the Health Insurance Exchange the basic benefit plan required by~~  
2340 ~~Section 31A-22-613.5; and]~~

2341       ~~[(ii) may publish on the Health Insurance Exchange any other health benefit plans that~~  
2342 ~~it offers in the individual market:]~~

2343       ~~[(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:]~~

2344       ~~[(i) shall comply with the provisions of this section for every health benefit plan it~~  
2345 ~~posts on the Health Insurance Exchange; and]~~

2346       ~~[(ii) may not offer products on the Health Insurance Exchange that are not health~~  
2347 ~~benefit plans:]~~

2348       ~~[(4) A health insurer shall provide the Health Insurance Exchange with the following~~  
2349 ~~information for each health benefit plan submitted to the Health Insurance Exchange:]~~

2350       ~~[(a) plan design, benefits, and options offered by the health benefit plan including state~~  
2351 ~~mandates the plan does not cover;]~~

2352       ~~[(b) provider networks;]~~

2353       ~~[(c) wellness programs and incentives; and]~~

2354 ~~[(d) descriptions of prescription drug benefits, exclusions, or limitations.]~~  
 2355 ~~[(5) (a) An insurer offering any health benefit plan in the state shall submit the~~  
 2356 ~~information described in Subsection (5)(b) to the Insurance Department in the electronic format~~  
 2357 ~~required by Subsection (1).]~~  
 2358 ~~[(b) An insurer who offers a health benefit plan in the state shall submit to the Health~~  
 2359 ~~Insurance Exchange the following operational measures:]~~  
 2360 ~~[(i) the percentage of claims paid by the insurer within 30 days of the date a claim is~~  
 2361 ~~submitted to the insurer for the prior year; and]~~  
 2362 ~~[(ii) for all health benefit plans offered by the insurer in the state, the claims denial and~~  
 2363 ~~insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).]~~  
 2364 ~~[(c) The Insurance Department shall forward to the Health Insurance Exchange the~~  
 2365 ~~information submitted by an insurer in accordance with this section and Section~~  
 2366 ~~31A-22-613.5.]~~  
 2367 ~~[(6) The Insurance Department shall post on the Health Insurance Exchange the~~  
 2368 ~~Insurance Department's solvency rating for each insurer who posts a health benefit plan on the~~  
 2369 ~~Health Insurance Exchange. The solvency rating for each carrier shall be based on~~  
 2370 ~~methodology established by the Insurance Department by administrative rule and shall be~~  
 2371 ~~updated each calendar year.]~~  
 2372 ~~[(7) The commissioner may request information from an insurer under Section~~  
 2373 ~~31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health~~  
 2374 ~~Insurance Exchange under this section.]~~  
 2375 ~~[(8) A health insurer shall accept and process an application for a health benefit plan~~  
 2376 ~~from the Health Insurance Exchange in accordance with this section and Section 31A-22-635.]~~  
 2377 Section 34. Section **72-6-107.5** is amended to read:  
 2378 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**  
 2379 **insurance coverage.**  
 2380 (1) For purposes of this section:  
 2381 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section

2382 34A-2-104 who:

2383 (i) works at least 30 hours per calendar week; and

2384 (ii) meets employer eligibility waiting requirements for health care insurance which  
2385 may not exceed the first day of the calendar month following 90 days from the date of hire.

2386 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2387 (c) "Qualified health insurance coverage" ~~[means at the time the contract is entered into~~  
2388 ~~or renewed:]~~ is as defined in Section 26-40-115.

2389 ~~[(i) a health benefit plan and employer contribution level with a combined actuarial~~  
2390 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~  
2391 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~  
2392 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~  
2393 ~~employee who reside or work in the state, in which:]~~

2394 ~~[(A) the employer pays at least 50% of the premium for the employee and the~~  
2395 ~~dependents of the employee who reside or work in the state; and]~~

2396 ~~[(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]~~

2397 ~~[(F) rather than the benchmark plan's deductible, and the benchmark plan's~~  
2398 ~~out-of-pocket maximum based on income levels:]~~

2399 ~~[(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

2400 ~~[(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]~~

2401 ~~[(H) dental coverage is not required; and]~~

2402 ~~[(HH) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~  
2403 ~~not apply; or]~~

2404 ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~  
2405 ~~deductible that is either:]~~

2406 ~~[(F) the lowest deductible permitted for a federally qualified high deductible health~~  
2407 ~~plan; or]~~

2408 ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~  
2409 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~

2410 account in a dollar amount at least equal to the dollar amount difference between the lowest  
2411 deductible permitted for a federally qualified high deductible plan and the deductible for the  
2412 employer offered federally qualified high deductible plan;]

2413 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~  
2414 ~~annual deductible; and]~~

2415 [~~(C) under which the employer pays 75% of the premium for the employee and the~~  
2416 ~~dependents of the employee who work or reside in the state.]~~

2417 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2418 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered  
2419 into by the department on or after July 1, 2009, for construction or design of highways and to a  
2420 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

2421 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
2422 amount of \$1,500,000 or greater.

2423 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
2424 \$750,000 or greater.

2425 (3) This section does not apply if:

2426 (a) the application of this section jeopardizes the receipt of federal funds;

2427 (b) the contract is a sole source contract; or

2428 (c) the contract is an emergency procurement.

2429 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]  
2430 63G-6-103, or a modification to a contract, when the contract does not meet the initial  
2431 threshold required by Subsection (2).

2432 (b) A person who intentionally uses change orders or contract modifications to  
2433 circumvent the requirements of Subsection (2) is guilty of an infraction.

2434 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that  
2435 the contractor has and will maintain an offer of qualified health insurance coverage for the  
2436 contractor's employees and the employees' dependents during the duration of the contract.

2437 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall

2438 demonstrate to the department that the subcontractor has and will maintain an offer of qualified  
2439 health insurance coverage for the subcontractor's employees and the employees' dependents  
2440 during the duration of the contract.

2441 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during  
2442 the duration of the contract is subject to penalties in accordance with administrative rules  
2443 adopted by the department under Subsection (6).

2444 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
2445 requirements of Subsection (5)(b).

2446 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
2447 the duration of the contract is subject to penalties in accordance with administrative rules  
2448 adopted by the department under Subsection (6).

2449 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
2450 requirements of Subsection (5)(a).

2451 (6) The department shall adopt administrative rules:

2452 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2453 (b) in coordination with:

2454 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2455 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

2456 (iii) the State Building Board in accordance with Section 63A-5-205;

2457 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

2458 (v) a public transit district in accordance with Section 17B-2a-818.5; and

2459 (vi) the Legislature's Administrative Rules Review Committee; and

2460 (c) which establish:

2461 (i) the requirements and procedures a contractor must follow to demonstrate to the  
2462 department compliance with this section which shall include:

2463 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

2464 (b) more than twice in any 12-month period; and

2465 (B) that the actuarially equivalent determination required for qualified health insurance



2466 coverage in Subsection (1) is met by the contractor if the contractor provides the department or  
2467 division with a written statement of actuarial equivalency from either:

- 2468 (I) the Utah Insurance Department;
- 2469 (II) an actuary selected by the contractor or the contractor's insurer; or
- 2470 (III) an underwriter who is responsible for developing the employer group's premium  
2471 rates;

2472 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
2473 violates the provisions of this section, which may include:

- 2474 (A) a three-month suspension of the contractor or subcontractor from entering into  
2475 future contracts with the state upon the first violation;
- 2476 (B) a six-month suspension of the contractor or subcontractor from entering into future  
2477 contracts with the state upon the second violation;
- 2478 (C) an action for debarment of the contractor or subcontractor in accordance with  
2479 Section 63G-6-804 upon the third or subsequent violation; and
- 2480 (D) monetary penalties which may not exceed 50% of the amount necessary to  
2481 purchase qualified health insurance coverage for an employee and a dependent of the employee  
2482 of the contractor or subcontractor who was not offered qualified health insurance coverage  
2483 during the duration of the contract; and
- 2484 (iii) a website on which the department shall post the benchmark for the qualified  
2485 health insurance coverage identified in Subsection (1)(c)[(†)].

2486 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or  
2487 subcontractor who intentionally violates the provisions of this section shall be liable to the  
2488 employee for health care costs that would have been covered by qualified health insurance  
2489 coverage.

2490 (ii) An employer has an affirmative defense to a cause of action under Subsection  
2491 (7)(a)(i) if:

- 2492 (A) the employer relied in good faith on a written statement of actuarial equivalency  
2493 provided by:

2494 (I) an actuary; or  
2495 (II) an underwriter who is responsible for developing the employer group's premium  
2496 rates; or  
2497 (B) the department determines that compliance with this section is not required under  
2498 the provisions of Subsection (3) or (4).

2499 (b) An employee has a private right of action only against the employee's employer to  
2500 enforce the provisions of this Subsection (7).

2501 (8) Any penalties imposed and collected under this section shall be deposited into the  
2502 Medicaid Restricted Account created in Section 26-18-402.

2503 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
2504 coverage as required by this section:

2505 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
2506 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,  
2507 Legal and Contractual Remedies; and

2508 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
2509 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
2510 or construction.

2511 Section 35. Section **79-2-404** is amended to read:

2512 **79-2-404. Contracting powers of department -- Health insurance coverage.**

2513 (1) For purposes of this section:

2514 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section  
2515 34A-2-104 who:

2516 (i) works at least 30 hours per calendar week; and

2517 (ii) meets employer eligibility waiting requirements for health care insurance which  
2518 may not exceed the first day of the calendar month following 90 days from the date of hire.

2519 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2520 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~  
2521 ~~or renewed;~~] is as defined in Section 26-40-115.

2522 ~~[(i) a health benefit plan and employer contribution level with a combined actuarial~~  
2523 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~  
2524 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~  
2525 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~  
2526 ~~employee who reside or work in the state, in which:]~~

2527 ~~[(A) the employer pays at least 50% of the premium for the employee and the~~  
2528 ~~dependents of the employee who reside or work in the state; and]~~

2529 ~~[(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]~~

2530 ~~[(F) rather than the benchmark plan's deductible, and the benchmark plan's~~  
2531 ~~out-of-pocket maximum based on income levels:]~~

2532 ~~[(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

2533 ~~[(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]~~

2534 ~~[(H) dental coverage is not required; and]~~

2535 ~~[(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~  
2536 ~~not apply; or]~~

2537 ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~  
2538 ~~deductible that is either:]~~

2539 ~~[(F) the lowest deductible permitted for a federally qualified high deductible health~~  
2540 ~~plan; or]~~

2541 ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~  
2542 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~  
2543 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~  
2544 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~  
2545 ~~employer offered federally qualified high deductible plan;]~~

2546 ~~[(B) an out-of-pocket maximum that does not exceed three times the amount of the~~  
2547 ~~annual deductible; and]~~

2548 ~~[(C) under which the employer pays 75% of the premium for the employee and the~~  
2549 ~~dependents of the employee who work or reside in the state.]~~

- 2550 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
- 2551 (2) (a) Except as provided in Subsection (3), this section applies a design or  
2552 construction contract entered into by, or delegated to, the department or a division, board, or  
2553 council of the department on or after July 1, 2009, and to a prime contractor or to a  
2554 subcontractor in accordance with Subsection (2)(b).
- 2555 (b) (i) A prime contractor is subject to this section if the prime contract is in the  
2556 amount of \$1,500,000 or greater.
- 2557 (ii) A subcontractor is subject to this section if a subcontract is in the amount of  
2558 \$750,000 or greater.
- 2559 (3) This section does not apply to contracts entered into by the department or a  
2560 division, board, or council of the department if:
- 2561 (a) the application of this section jeopardizes the receipt of federal funds;
- 2562 (b) the contract or agreement is between:
- 2563 (i) the department or a division, board, or council of the department; and
- 2564 (ii) (A) another agency of the state;
- 2565 (B) the federal government;
- 2566 (C) another state;
- 2567 (D) an interstate agency;
- 2568 (E) a political subdivision of this state; or
- 2569 (F) a political subdivision of another state; or
- 2570 (c) the contract or agreement is:
- 2571 (i) for the purpose of disbursing grants or loans authorized by statute;
- 2572 (ii) a sole source contract; or
- 2573 (iii) an emergency procurement.
- 2574 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]  
2575 63G-6-103, or a modification to a contract, when the contract does not meet the initial  
2576 threshold required by Subsection (2).
- 2577 (b) A person who intentionally uses change orders or contract modifications to

2578 circumvent the requirements of Subsection (2) is guilty of an infraction.

2579           (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department  
2580 that the contractor has and will maintain an offer of qualified health insurance coverage for the  
2581 contractor's employees and the employees' dependents during the duration of the contract.

2582           (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor  
2583 shall demonstrate to the department that the subcontractor has and will maintain an offer of  
2584 qualified health insurance coverage for the subcontractor's employees and the employees'  
2585 dependents during the duration of the contract.

2586           (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during  
2587 the duration of the contract is subject to penalties in accordance with administrative rules  
2588 adopted by the department under Subsection (6).

2589           (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the  
2590 requirements of Subsection (5)(b).

2591           (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during  
2592 the duration of the contract is subject to penalties in accordance with administrative rules  
2593 adopted by the department under Subsection (6).

2594           (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the  
2595 requirements of Subsection (5)(a).

2596           (6) The department shall adopt administrative rules:

2597           (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2598           (b) in coordination with:

2599           (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2600           (ii) a public transit district in accordance with Section 17B-2a-818.5;

2601           (iii) the State Building Board in accordance with Section 63A-5-205;

2602           (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

2603           (v) the Department of Transportation in accordance with Section 72-6-107.5; and

2604           (vi) the Legislature's Administrative Rules Review Committee; and

2605           (c) which establish:

2606 (i) the requirements and procedures a contractor must follow to demonstrate  
2607 compliance with this section to the department which shall include:  
2608 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or  
2609 (b) more than twice in any 12-month period; and  
2610 (B) that the actuarially equivalent determination required for qualified health insurance  
2611 coverage in Subsection (1) is met by the contractor if the contractor provides the department or  
2612 division with a written statement of actuarial equivalency from either:  
2613 (I) the Utah Insurance Department;  
2614 (II) an actuary selected by the contractor or the contractor's insurer; or  
2615 (III) an underwriter who is responsible for developing the employer group's premium  
2616 rates;  
2617 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
2618 violates the provisions of this section, which may include:  
2619 (A) a three-month suspension of the contractor or subcontractor from entering into  
2620 future contracts with the state upon the first violation;  
2621 (B) a six-month suspension of the contractor or subcontractor from entering into future  
2622 contracts with the state upon the second violation;  
2623 (C) an action for debarment of the contractor or subcontractor in accordance with  
2624 Section 63G-6-804 upon the third or subsequent violation; and  
2625 (D) monetary penalties which may not exceed 50% of the amount necessary to  
2626 purchase qualified health insurance coverage for an employee and a dependent of an employee  
2627 of the contractor or subcontractor who was not offered qualified health insurance coverage  
2628 during the duration of the contract; and  
2629 (iii) a website on which the department shall post the benchmark for the qualified  
2630 health insurance coverage identified in Subsection (1)(c)[(†)].  
2631 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or  
2632 subcontractor who intentionally violates the provisions of this section shall be liable to the  
2633 employee for health care costs that would have been covered by qualified health insurance

2634 coverage.

2635 (ii) An employer has an affirmative defense to a cause of action under Subsection  
2636 (7)(a)(i) if:

2637 (A) the employer relied in good faith on a written statement of actuarial equivalency  
2638 provided by:

2639 (I) an actuary; or

2640 (II) an underwriter who is responsible for developing the employer group's premium  
2641 rates; or

2642 (B) the department determines that compliance with this section is not required under  
2643 the provisions of Subsection (3) or (4).

2644 (b) An employee has a private right of action only against the employee's employer to  
2645 enforce the provisions of this Subsection (7).

2646 (8) Any penalties imposed and collected under this section shall be deposited into the  
2647 Medicaid Restricted Account created in Section 26-18-402.

2648 (9) The failure of a contractor or subcontractor to provide qualified health insurance  
2649 coverage as required by this section:

2650 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
2651 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,  
2652 Legal and Contractual Remedies; and

2653 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
2654 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
2655 or construction.

2656 **Section 36. Repealer.**

2657 This bill repeals:

2658 **Section 31A-42a-101 (Effective 01/01/13), Title.**

2659 **Section 31A-42a-102 (Effective 01/01/13), Definitions.**

2660 **Section 31A-42a-201 (Effective 01/01/13), Creation of defined contribution market**  
2661 **risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan**

2662 **preparation.**

2663 Section 31A-42a-202 (Effective 01/01/13), Contents of plan.

2664 Section 31A-42a-203 (Effective 01/01/13), Powers and duties of board.

2665 Section 31A-42a-204 (Effective 01/01/13), Powers of commissioner.

2666 Section 37. **Health System Reform Task Force -- Creation -- Membership --**

2667 **Interim rules followed -- Compensation -- Staff.**

2668 (1) There is created the Health System Reform Task Force consisting of the following  
2669 11 members:

2670 (a) four members of the Senate appointed by the president of the Senate, no more than  
2671 three of whom may be from the same political party; and

2672 (b) seven members of the House of Representatives appointed by the speaker of the  
2673 House of Representatives, no more than five of whom may be from the same political party.

2674 (2) (a) The president of the Senate shall designate a member of the Senate appointed  
2675 under Subsection (1)(a) as a cochair of the committee.

2676 (b) The speaker of the House of Representatives shall designate a member of the House  
2677 of Representatives appointed under Subsection (1)(b) as a cochair of the committee.

2678 (3) In conducting its business, the committee shall comply with the rules of legislative  
2679 interim committees.

2680 (4) Salaries and expenses of the members of the committee shall be paid in accordance  
2681 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage  
2682 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override  
2683 Sessions.

2684 (5) The Office of Legislative Research and General Counsel shall provide staff support  
2685 to the committee.

2686 Section 38. **Duties -- Interim report.**

2687 (1) The task force shall review and make recommendations on the following issues:

2688 (a) the state's response to federal health care reform, including whether the state should  
2689 develop an American Health Benefit Exchange under the federal Affordable Care Act for



2690 individual health benefit plans, individual premium assistance, tax credits, and Medicaid  
2691 eligibility determinations;  
2692 (b) legislation necessary to implement:  
2693 (i) the governance structure for the Health Insurance Exchange to:  
2694 (A) preserve the market-based defined contribution model for employers in the Health  
2695 Insurance Exchange;  
2696 (B) provide better control of state expenditures on health care for state employees,  
2697 retirees, and their families;  
2698 (C) incentives to improve health among state employees; and  
2699 (D) position Utah to continue with a market based, consumer driven insurance  
2700 exchange;  
2701 (ii) an operational blue print for the Health Insurance Exchange to promote an  
2702 appropriate balance between private sector solutions and efficiencies for the exchange and state  
2703 regulatory functions related to insurance market conduct; and  
2704 (iii) funding requirements associated with the governance structure and better use of  
2705 the Public Employees' Benefit and Insurance Program assets and competencies;  
2706 (c) which market regulatory functions should be given to the Health Insurance  
2707 Exchange and which should remain with the Insurance Department, the Department of Health,  
2708 or the Department of Workforce Services;  
2709 (d) policy and guidance regarding the state's implementation of the small group defined  
2710 contribution arrangement market on the Health Insurance Exchange, including the consumer  
2711 experience and information on the exchange concerning cost, quality, and transparency;  
2712 (e) whether the risk adjuster mechanism in the exchange should be modified;  
2713 (f) health care cost containment issues, including:  
2714 (i) progress on the demonstration projects and grants that involve health care providers  
2715 and payers to provide systemwide aligned incentives for the appropriate delivery of, and  
2716 payment for, health care; and  
2717 (ii) effective tools for reducing the cost or perceived costs of medical malpractice

2718 liability in the health care system; and

2719 (g) the appropriate balance of cost and benefits provided by insurance plans available  
2720 on the exchange, including possible consideration of spiritual care, vision care, and dental  
2721 services.

2722 (2) The task force shall coordinate with the Legislative Retirement and Independent  
2723 Entities Interim Committee when it studies and makes recommendations regarding operational  
2724 functions of the Health Insurance Exchange as it relates to state expenditures for health  
2725 insurance for public employees, retirees, and their families.

2726 (3) A final report, including any proposed legislation, shall be presented to the Health  
2727 and Human Services Interim Committee before November 30, 2011.

2728 Section 39. **Intent language regarding lapsing of money.**

2729 It is the intent of the Legislature that money received by the Insurance Department  
2730 during fiscal year 2010-11 under Section 31A-30-115 shall be considered dedicated credits and  
2731 in closing out the fiscal year 2010-11 the unspent dedicated credits shall lapse to the Health  
2732 Insurance Actuarial Review Restricted Account.

2733 Section 40. **Repeal date.**

2734 (1) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Sections 48 and 49,  
2735 which enacted the 2010 Health System Reform Task Force.

2736 (2) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Section 50,  
2737 Subsection (3), which provided a future effective date of January 1, 2013, for Title 31A,  
2738 Chapter 42a, Utah Statewide Risk Adjuster Act.

2739 (3) The Health System Reform Task Force created in Sections 37 and 38 of this bill is  
2740 repealed on December 30, 2011.