

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH SYSTEM REFORM AMENDMENTS

2013 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Evan J. Vickers

LONG TITLE

General Description:

This bill amends provisions in the Insurance Code and in Governor's Programs related to health system reform.

Highlighted Provisions:

This bill:

- ▶ authorizes the insurance commissioner to regulate the state insurance market as it transitions to new rating practices and health plan requirements of federal law;
- ▶ gives insurance producers and agents the authority to sell, solicit, and negotiate health insurance on a federal health insurance exchange;
- ▶ permits an insurer to pass through commission payments from an insured to a producer;
- ▶ establishes the requirements for a navigator license;
- ▶ amends definitions in the Individual, Small Employer and Group Health Insurance Act;
- ▶ establishes separate risk pools for the individual health insurance market and the small group health insurance market;
- ▶ amends discontinuation and nonrenewal limitations and conditions;
- ▶ amends small employer participation and contribution requirements;



- 26 ▶ amends provisions regarding actuarial review of rates;
- 27 ▶ gives the commissioner administrative rulemaking authority to facilitate state
- 28 regulation of insurers, qualified health plans, and the health insurance market when
- 29 federal insurance exchanges begin operating in the state, including:
 - 30 • rate review and approval; and
 - 31 • creating uniform open enrollment periods for the individual health
 - 32 insurance market;
- 33 ▶ removes the requirement that a carrier in Utah's defined contribution arrangement
- 34 market (Avenue H) must offer certain health benefit products on Avenue H;
- 35 ▶ authorizes free-standing dental and vision plans on Utah's Avenue H;
- 36 ▶ extends the sunset date for the Risk Adjuster Board for the defined contribution
- 37 arrangement market;
- 38 ▶ removes the rating parity requirement for plans offered on Avenue H;
- 39 ▶ establishes regulations for stop-loss and re-insurance insurers for small employers;
- 40 ▶ establishes the general insurance laws that apply to small employer stop-loss
- 41 insurers;
- 42 ▶ applies the regulations to stop-loss contracts issued or renewed on or after July 1,
- 43 2013;
- 44 ▶ gives the commissioner administrative rulemaking authority.
- 45 ▶ makes technical amendments;
- 46 ▶ amends executive branch reporting requirements related to the Patient Protection
- 47 and Affordable Care Act (PPACA) implementation; and
- 48 ▶ reauthorizes the Health System Reform Task Force until December 30, 2015.

49 **Money Appropriated in this Bill:**

- 50 This bill appropriates in fiscal year 2013-14:
- 51 ▶ to the Legislature-Senate as a one-time appropriation:
 - 52 • from the General Fund, One-time, \$30,000
 - 53 ▶ to the Legislature-House as a one-time appropriation:
 - 54 • from the General Fund, One-time, \$52,000.

55 **Other Special Clauses:**

56 This bill provides an effective date.

57 This bill provides a repeal date.

58 **Utah Code Sections Affected:**

59 AMENDS:

60 **31A-2-212**, as last amended by Laws of Utah 2011, Chapters 284 and 400

61 **31A-23a-501**, as last amended by Laws of Utah 2012, Chapter 279

62 **31A-30-104**, as last amended by Laws of Utah 2011, Chapter 400

63 **31A-30-105**, as last amended by Laws of Utah 2011, Chapter 284

64 **31A-30-107.3**, as last amended by Laws of Utah 2011, Chapter 297

65 **31A-30-112**, as last amended by Laws of Utah 2012, Chapter 253

66 **31A-30-115**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5

67 **31A-30-208**, as last amended by Laws of Utah 2011, Chapter 400

68 **63I-2-231 (Superseded 07/01/13)**, as last amended by Laws of Utah 2012, Chapter 279

69 **63I-2-231 (Effective 07/01/13)**, as last amended by Laws of Utah 2012, Chapters 243

70 and 279

71 **63M-1-2505.5**, as enacted by Laws of Utah 2010, Chapter 51

72 ENACTS:

73 **31A-23a-208**, Utah Code Annotated 1953

74 **31A-23b-101**, Utah Code Annotated 1953

75 **31A-23b-102**, Utah Code Annotated 1953

76 **31A-23b-201**, Utah Code Annotated 1953

77 **31A-23b-202**, Utah Code Annotated 1953

78 **31A-23b-203**, Utah Code Annotated 1953

79 **31A-23b-204**, Utah Code Annotated 1953

80 **31A-23b-205**, Utah Code Annotated 1953

81 **31A-23b-206**, Utah Code Annotated 1953

82 **31A-23b-207**, Utah Code Annotated 1953

83 **31A-23b-208**, Utah Code Annotated 1953

84 **31A-23b-209**, Utah Code Annotated 1953

85 **31A-23b-210**, Utah Code Annotated 1953

86 **31A-23b-211**, Utah Code Annotated 1953

87 **31A-23b-301**, Utah Code Annotated 1953

- 88 **31A-23b-401**, Utah Code Annotated 1953
- 89 **31A-23b-402**, Utah Code Annotated 1953
- 90 **31A-23b-403**, Utah Code Annotated 1953
- 91 **31A-23b-404**, Utah Code Annotated 1953
- 92 **31A-30-117**, Utah Code Annotated 1953
- 93 **31A-30-202.6**, Utah Code Annotated 1953
- 94 **31A-43-101**, Utah Code Annotated 1953
- 95 **31A-43-102**, Utah Code Annotated 1953
- 96 **31A-43-201**, Utah Code Annotated 1953
- 97 **31A-43-202**, Utah Code Annotated 1953
- 98 **31A-43-301**, Utah Code Annotated 1953
- 99 **31A-43-302**, Utah Code Annotated 1953
- 100 **31A-43-303**, Utah Code Annotated 1953
- 101 **31A-43-304**, Utah Code Annotated 1953

102 **Uncodified Material Affected:**

103 ENACTS UNCODIFIED MATERIAL

104

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

105 Section 1. Section **31A-2-212** is amended to read:

106 **31A-2-212. Miscellaneous duties.**

107 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to
108 do business in Utah, and when the commissioner begins a proceeding against an insurer under
109 Chapter 27a, Insurer Receivership Act, the commissioner:

110 (a) shall notify by mail the producers of the person or insurer of whom the
111 commissioner has record; and

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

114 (2) When required for evidence in a legal proceeding, the commissioner shall furnish a
115 certificate of authority of a licensee to transact the business of insurance in Utah on any
116 particular date. The court or other officer shall receive the certificate of authority in lieu of the
117 commissioner's testimony.
118

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

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

124 (c) After a certified copy of a certificate of authority is furnished to a public officer, it
125 is not necessary, while the certificate of authority remains effective, to attach a copy of it to any
126 instrument of suretyship filed with that public officer.

127 (d) Whenever the commissioner revokes the certificate of authority or begins a
128 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a
129 surety business, the commissioner shall immediately give notice of that action to each public
130 officer who is sent a certified copy under this Subsection (3).

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

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

134 (A) files a petition for receivership; or

135 (B) is in receivership; or

136 (ii) the commissioner has reason to believe that the authorized insurer doing surety
137 business:

138 (A) is in financial difficulty; or

139 (B) has unreasonably failed to carry out any of its contracts.

140 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the
141 judges and clerks to notify and require a person that files with the court a bond on which the
142 authorized insurer doing surety business is surety to immediately file a new bond with a new
143 surety.

144 (5) (a) The commissioner shall report to the Legislature in accordance with Section
145 63M-1-2505.5 prior to adopting a rule authorized by Subsection (5)(b).

146 (b) The commissioner shall require an insurer that issues, sells, renews, or offers health
147 insurance coverage in this state to comply with~~[(a) the Health Insurance Portability and~~
148 Accountability Act, Pub. L. No. 104-191, and~~(b) subject to Section 63M-1-2505.5, and to the~~
149 extent required or applicable under the provisions of the Patient Protection and Affordable

150 ~~Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub.~~
 151 ~~L. No. 111-152,]~~ the provisions of PPACA and administrative rules adopted by the
 152 commissioner related to regulation of health benefit plans, including:

- 153 (i) lifetime and annual limits;
- 154 (ii) prohibition of rescissions;
- 155 (iii) coverage of preventive health services;
- 156 (iv) coverage for a child or dependent;
- 157 (v) pre-existing condition coverage for children;
- 158 (vi) insurer transparency of consumer information including plan disclosures, uniform
- 159 coverage documents, and standard definitions;
- 160 (vii) premium rate reviews;
- 161 (viii) essential health benefits;
- 162 (ix) provider choice;
- 163 (x) waiting periods; [~~and~~]
- 164 (xi) appeals processes[-];
- 165 (xii) rating restrictions;
- 166 (xiii) uniform applications and notice provisions; and
- 167 (xiv) certification and regulation of qualified health plans.

168 (c) The commissioner shall preserve state control over:

- 169 (i) the health insurance market in the state;
- 170 (ii) qualified health plans offered in the state; and
- 171 (iii) the conduct of navigators, producers, and in-person assisters operating in the state.

171a **§→ (d) If the state enters into an agreement with the United States' Department of**
 171b **Health and Human Services in which the state operates health insurance plan management,**
 171c **the commissioner may:**

- 171d **(i) for fiscal year 2014, hire one temporary and two permanent full-time employees to**
 171e **be funded through the department's existing budget; and**
- 171f **(ii) for fiscal year 2015, hire two permanent full-time employees funded through the**
 171g **Insurance Department Restricted Account, subject to appropriations from the Legislature and**
 171h **approval by the governor. ←§**

172 Section 2. Section 31A-23a-208 is enacted to read:

173 **31A-23a-208. Producer and agency authority in health insurance exchange.**

174 A producer or agency licensed under this chapter, with a line of authority that permits
 175 the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized

176 to sell, negotiate, or solicit qualified health plans offered on an exchange that is:

177 (1) operated in the state; or

178 (2) operated in the state and certified by the United States Department of Health and

179 Human Services as a:

180 (a) state-based exchange under PPACA;

181 (b) a federally facilitated exchange under PPACA; or

182 (c) a partnership exchange under PPACA.

183 Section 3. Section **31A-23a-501** is amended to read:

184 **31A-23a-501. Licensee compensation.**

185 (1) As used in this section:

186 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
187 licensee from:

188 (i) commission amounts deducted from insurance premiums on insurance sold by or
189 placed through the licensee; or

190 (ii) commission amounts received from an insurer or another licensee as a result of the
191 sale or placement of insurance.

192 (b) (i) "Compensation from an insurer or third party administrator" means
193 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
194 gifts, prizes, or any other form of valuable consideration:

195 (A) whether or not payable pursuant to a written agreement; and

196 (B) received from:

197 (I) an insurer; or

198 (II) a third party to the transaction for the sale or placement of insurance.

199 (ii) "Compensation from an insurer or third party administrator" does not mean
200 compensation from a customer that is:

201 (A) a fee or pass-through costs as provided in Subsection (1)(e); or

202 (B) a fee or amount collected by or paid to the producer that does not exceed an
203 amount established by the commissioner by administrative rule.

204 (c) (i) "Customer" means:

205 (A) the person signing the application or submission for insurance; or

206 (B) the authorized representative of the insured actually negotiating the placement of
207 insurance with the producer.

208 (ii) "Customer" does not mean a person who is a participant or beneficiary of:

209 (A) an employee benefit plan; or

210 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
211 negotiated by the producer or affiliate.

212 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
213 benefit of a licensee other than commission compensation.

214 (ii) "Noncommission compensation" does not include charges for pass-through costs
215 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

216 (e) "Pass-through costs" include:

217 (i) costs for copying documents to be submitted to the insurer; and

218 (ii) bank costs for processing cash or credit card payments.

219 (2) A licensee may receive from an insured or from a person purchasing an insurance
220 policy, noncommission compensation if the noncommission compensation is stated on a
221 separate, written disclosure.

222 (a) The disclosure required by this Subsection (2) shall:

223 (i) include the signature of the insured or prospective insured acknowledging the
224 noncommission compensation;

225 (ii) clearly specify the amount or extent of the noncommission compensation; and

226 (iii) be provided to the insured or prospective insured before the performance of the
227 service.

228 (b) Noncommission compensation shall be:

229 (i) limited to actual or reasonable expenses incurred for services; and

230 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
231 business or for a specific service or services.

232 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained
233 by any licensee who collects or receives the noncommission compensation or any portion of
234 the noncommission compensation.

235 (d) All accounting records relating to noncommission compensation shall be
236 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

237 (3) (a) A licensee may receive noncommission compensation when acting as a
238 producer for the insured in connection with the actual sale or placement of insurance if:

239 (i) the producer and the insured have agreed on the producer's noncommission
240 compensation; and

241 (ii) the producer has disclosed to the insured the existence and source of any other
242 compensation that accrues to the producer as a result of the transaction.

- 243 (b) The disclosure required by this Subsection (3) shall:
- 244 (i) include the signature of the insured or prospective insured acknowledging the
- 245 noncommission compensation;
- 246 (ii) clearly specify the amount or extent of the noncommission compensation and the
- 247 existence and source of any other compensation; and
- 248 (iii) be provided to the insured or prospective insured before the performance of the
- 249 service.
- 250 (c) The following additional noncommission compensation is authorized:
- 251 (i) compensation received by a producer of a compensated corporate surety who under
- 252 procedures approved by a rule or order of the commissioner is paid by surety bond principal
- 253 debtors for extra services;
- 254 (ii) compensation received by an insurance producer who is also licensed as a public
- 255 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
- 256 claim adjustment, so long as the producer does not receive or is not promised compensation for
- 257 aiding in the claim adjustment prior to the occurrence of the claim;
- 258 (iii) compensation received by a consultant as a consulting fee, provided the consultant
- 259 complies with the requirements of Section 31A-23a-401; or
- 260 (iv) other compensation arrangements approved by the commissioner after a finding
- 261 that they do not violate Section 31A-23a-401 and are not harmful to the public.
- 262 (d) Subject to Section 31A-23a-402.5, a producer for the insured may receive
- 263 compensation from an insured through an insurer, for the negotiation and sale of a health
- 264 benefit plan, if there is a separate written agreement between the insured and the licensee for
- 265 the compensation. An insurer who passes through the compensation from the insured to the
- 266 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or
- 267 commission compensation to the licensee.
- 268 (4) (a) For purposes of this Subsection (4), "producer" includes:
- 269 (i) a producer;
- 270 (ii) an affiliate of a producer; or
- 271 (iii) a consultant.
- 272 (b) A producer may not accept or receive any compensation from an insurer or third
- 273 party administrator for the initial placement of a health benefit plan, other than a hospital

274 confinement indemnity policy, unless prior to the customer's initial purchase of the health
275 benefit plan the producer discloses in writing to the customer that the producer will receive
276 compensation from the insurer or third party administrator for the placement of insurance,
277 including the amount or type of compensation known to the producer at the time of the
278 disclosure.

279 (c) A producer shall:

280 (i) obtain the customer's signed acknowledgment that the disclosure under Subsection
281 (4)(b) was made to the customer; or

282 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to
283 the customer; and

284 (B) keep the signed statement on file in the producer's office while the health benefit
285 plan placed with the customer is in force.

286 (d) (i) A licensee who collects or receives any part of the compensation from an insurer
287 or third party administrator in a manner that facilitates an audit shall, while the health benefit
288 plan placed with the customer is in force, maintain a copy of:

289 (A) the signed acknowledgment described in Subsection (4)(c)(i); or

290 (B) the signed statement described in Subsection (4)(c)(ii).

291 (ii) The standard application developed in accordance with Section 31A-22-635 shall
292 include a place for a producer to provide the disclosure required by this Subsection (4), and if
293 completed, shall satisfy the requirement of Subsection (4)(d)(i).

294 (e) Subsection (4)(c) does not apply to:

295 (i) a person licensed as a producer who acts only as an intermediary between an insurer
296 and the customer's producer, including a managing general agent; or

297 (ii) the placement of insurance in a secondary or residual market.

298 (5) This section does not alter the right of any licensee to recover from an insured the
299 amount of any premium due for insurance effected by or through that licensee or to charge a
300 reasonable rate of interest upon past-due accounts.

301 (6) This section does not apply to bail bond producers or bail enforcement agents as
302 defined in Section 31A-35-102.

303 (7) A licensee may not receive noncommission compensation from an insured or
304 enrollee for providing a service or engaging in an act that is required to be provided or

305 performed in order to receive commission compensation, except for the surplus lines
306 transactions that do not receive commissions.

307 Section 4. Section 31A-23b-101 is enacted to read:

308 **CHAPTER 23b. NAVIGATOR LICENSE ACT**

309 **Part 1. General Provisions**

310 **31A-23b-101. Title.**

311 This chapter is known as the "Navigator License Act."

312 Section 5. Section 31A-23b-102 is enacted to read:

313 **31A-23b-102. Definitions.**

314 As used in this chapter:

315 (1) "Compensation" is as defined in:

316 (a) Subsections 31A-23a-501(1)(a), (b), and (d); and

317 (b) PPACA.

318 (2) "Enroll" and "enrollment" mean to:

319 (a) (i) obtain personally identifiable information about an individual; and

320 (ii) inform an individual about accident and health insurance plans or public programs

321 offered on an exchange;

322 (b) solicit insurance; or

323 (c) submit to the exchange;

324 (i) personally identifiable information about an individual; and

325 (ii) an individual's selection of a particular accident and health insurance plan or public

326 program offered on the exchange.

327 (3) (a) "Exchange" means an online marketplace:

328 (i) for an individual to purchase a qualified health plan; and

329 (ii) that is certified by the United States Department of Health and Human Services as

330 either a state-based exchange or a federally facilitated exchange under PPACA.

331 (b) (i) "Exchange" does not include:

332 (A) an online marketplace for the purchase of health insurance if the online

333 marketplace is not a certified exchange under PPACA; or

334 (B) except as provided in Subsection (3)(b)(ii), an online marketplace for small

335 employers that is certified as a PPACA compliant SHOP exchange.

336 (ii) For purposes of this chapter, exchange does include a small employer SHOP
337 exchange described under Subsection (3)(b)(i)(B) if:

338 (A) federal regulations under PPACA require a small employer exchange to allow
339 navigators to assist small employers and their employees with selection of qualified health
340 plans on a small employer exchange; and

341 (B) the state has not entered into an agreement with the United States Department of
342 Health and Human Services that permits the state to limit the scope of practice of navigators to
343 only the individual PPACA exchange.

344 (4) "Navigator":

345 (a) means a person who facilitates enrollment in an exchange by offering to assist, or
346 who advertises any services to assist, with:

347 (i) the selection of and enrollment in a qualified health plan or a public program
348 offered on an exchange; or

349 (ii) applying for premium subsidies through an exchange; and

350 (b) includes a person who is an in-person assister or an application assister as described
351 in:

352 (i) federal regulations or guidance issued under PPACA; and

353 (ii) the state exchange blueprint published by the Center for Consumer Information and
354 Insurance Oversight within the Centers for Medicare and Medicaid Services in the United
355 States Department of Health and Human Services.

356 (5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

357 (6) "Public programs" means the state Medicaid program in Title 26, Chapter 18,
358 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

359 (7) "Solicit" is as defined in Section 31A-23a-102.

360 Section 6. Section **31A-23b-201** is enacted to read:

361 **Part 2. Licensing**

362 **31A-23b-201. Requirement of license.**

363 (1) (a) Except as provided in Section 31A-23b-211, a person may not perform, offer to
364 perform, or advertise any service as a navigator in the state, without:

365 (i) a valid navigator license issued under this chapter; or

366 (ii) a valid producer license under Subsection 31A-23a-106(2)(a) with a line of

367 authority that permits the person to sell, negotiate, or solicit accident and health insurance.

368 (b) A person may not utilize the services of another as a navigator if that person knows
369 or should know that the other person does not have a license as required by law.

370 (2) An insurance contract is not invalid as a result of a violation of this section.

371 Section 7. Section **31A-23b-202** is enacted to read:

372 **31A-23b-202. Qualifications for a license.**

373 (1) (a) The commissioner shall issue or renew a license to a person to act as a navigator
374 if the person:

375 (i) satisfies the:

376 (A) application requirements under Section 31A-23b-203;

377 (B) character requirements under Section 31A-23b-204;

378 (C) examination and training requirements under Section 31A-23b-205; and

379 (D) continuing education requirements under Section 31A-23b-206;

380 (ii) certifies that, to the extent applicable, the applicant:

381 (A) is in compliance with the surety bond requirements of Section 31A-23b-207; and

382 (B) will maintain compliance with Section 31A-23b-207 during the period for which
383 the license is issued or renewed; and

384 (iii) has not committed an act that is a ground for denial, suspension, or revocation as
385 provided in Section 31A-23b-401.

386 (b) A license issued under this chapter is valid for two years.

387 (2) (a) A person shall report to the commissioner:

388 (i) an administrative action taken against the person, including a denial of a new or
389 renewal license application:

390 (A) in another jurisdiction; or

391 (B) by another regulatory agency in this state; and

392 (ii) a criminal prosecution taken against the person in any jurisdiction.

393 (b) The report required by Subsection (2)(a) shall be filed:

394 (i) at the time the person files the application for an individual or agency license; and

395 (ii) for an action or prosecution that occurs on or after the day on which the person files
396 the application:

397 (A) for an administrative action, within 30 days of the final disposition of the

398 administrative action; or

399 (B) for a criminal prosecution, within 30 days of the initial appearance before a court.

400 (c) The report required by Subsection (2)(a) shall include a copy of the complaint or

401 other relevant legal documents related to the action or prosecution described in Subsection

402 (2)(a).

403 (3) (a) The department may:

404 (i) require a person applying for a license to submit to a criminal background check as
405 a condition of receiving a license; or

406 (ii) accept a background check conducted by another organization.

407 (b) A person, if required to submit to a criminal background check under Subsection

408 (3)(a), shall:

409 (i) submit a fingerprint card in a form acceptable to the department; and

410 (ii) consent to a fingerprint background check by:

411 (A) the Utah Bureau of Criminal Identification; and

412 (B) the Federal Bureau of Investigation.

413 (c) For a person who submits a fingerprint card and consents to a fingerprint

414 background check under Subsection (3)(b), the department may request:

415 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
416 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

417 (ii) complete Federal Bureau of Investigation criminal background checks through the
418 national criminal history system.

419 (d) Information obtained by the department from the review of criminal history records
420 received under this Subsection (3) shall be used by the department for the purposes of:

421 (i) determining if a person satisfies the character requirements under Section

422 31A-23b-204 for issuance or renewal of a license;

423 (ii) determining if a person failed to maintain the character requirements under Section
424 31A-23b-204; and

425 (iii) preventing a person who violates the federal Violent Crime Control and Law

426 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or
427 in-person assistor in the state.

428 (e) If the department requests the criminal background information, the department

429 shall:

430 (i) pay to the Department of Public Safety the costs incurred by the Department of
431 Public Safety in providing the department criminal background information under Subsection
432 (3)(c)(i);

433 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
434 of Investigation in providing the department criminal background information under
435 Subsection (3)(c)(ii); and

436 (iii) charge the person applying for a license a fee equal to the aggregate of Subsections
437 (3)(e)(i) and (ii).

438 (4) The commissioner may deny an application for a license under this chapter if the
439 person applying for the license:

440 (a) fails to satisfy the requirements of this section; or

441 (b) commits an act that is grounds for denial, suspension, or revocation as set forth in
442 Section 31A-23b-401.

443 Section 8. Section **31A-23b-203** is enacted to read:

444 **31A-23b-203. Application for individual license -- Application for agency license.**

445 (1) This section applies to an initial or renewal license as a navigator.

446 (2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an
447 individual shall:

448 (i) file an application for an initial or renewal individual license with the commissioner
449 on forms and in a manner the commissioner prescribes; and

450 (ii) pay a license fee that is not refunded if the application:

451 (A) is denied; or

452 (B) is incomplete when filed and is never completed by the applicant.

453 (b) An application described in this Subsection (2) shall provide:

454 (i) information about the applicant's identity;

455 (ii) the applicant's Social Security number;

456 (iii) the applicant's personal history, experience, education, and business record;

457 (iv) whether the applicant is 18 years of age or older;

458 (v) whether the applicant has committed an act that is a ground for denial, suspension,
459 or revocation as set forth in Section 31A-23b-401 or 31A-23b-402;

460 (vi) that the applicant complies with the surety bond requirements of Section
461 31A-23b-207;

462 (vii) that the applicant completed the training requirements in Section 31A-23b-205;
463 and

464 (viii) any other information the commissioner reasonably requires.

465 (3) The commissioner may require a document reasonably necessary to verify the
466 information contained in an application filed under this section.

467 (4) An applicant's Social Security number contained in an application filed under this
468 section is a private record under Section 63G-2-302.

469 (5) (a) Subject to Subsection (5)(b), to obtain or renew a navigator agency license, a
470 person shall:

471 (i) file an application for an initial or renewal navigator agency license with the
472 commissioner on forms and in a manner the commissioner prescribes; and

473 (ii) pay a license fee that is not refunded if the application:

474 (A) is denied; or

475 (B) is incomplete when filed and is never completed by the applicant.

476 (b) An application described in Subsection (5)(a) shall provide:

477 (i) information about the applicant's identity;

478 (ii) the applicant's federal employer identification number;

479 (iii) the designated responsible licensed individual;

480 (iv) the identity of the owners, partners, officers, and directors;

481 (v) whether the applicant, or individual identified in Subsections (5)(b)(iii) and (iv),
482 has committed an act that is a ground for denial, suspension, or revocation as set forth in
483 Section 31A-23b-401; and

484 (vi) any other information the commissioner reasonably requires.

485 Section 9. Section **31A-23b-204** is enacted to read:

486 **31A-23b-204. Character requirements.**

487 An applicant for a license under this chapter shall demonstrate to the commissioner
488 that:

489 (1) the applicant has the intent, in good faith, to engage in the practice of a navigator as
490 the license would permit;

- 491 (2) (a) if a natural person, the applicant is competent and trustworthy; or
492 (b) if the applicant is an agency:
493 (i) the partners, directors, or principal officers or persons having comparable powers
494 are trustworthy; and
495 (ii) that it will transact business in a way that the acts that may only be performed by a
496 licensed navigator are performed only by a natural person who is licensed under this chapter, or
497 Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance
498 Intermediaries;
499 (3) the applicant intends to comply with the surety bond requirements of Section
500 31A-23b-207;
501 (4) if a natural person, the applicant is at least 18 years of age; and
502 (5) the applicant does not have a conflict of interest as defined by regulations issued
503 under PPACA.

504 Section 10. Section **31A-23b-205** is enacted to read:

505 **31A-23b-205. Examination and training requirements.**

- 506 (1) The commissioner may require applicants for a license to pass an examination and
507 complete a training program as a requirement for a license.
508 (2) The examination described in Subsection (1) shall reasonably relate to:
509 (a) the duties and functions of a navigator;
510 (b) requirements for navigators as established by federal regulation under PPACA; and
511 (c) other requirements that may be established by the commissioner by administrative
512 rule.
513 (3) The examination may be administered by the commissioner or as otherwise
514 specified by administrative rule.
515 (4) The training required by Subsection (1) shall be approved by the commissioner and
516 shall include:
517 (a) accident and health insurance plans;
518 (b) qualifications for and enrollment in public programs;
519 (c) qualifications for and enrollment in premium subsidies;
520 (d) cultural and linguistic competence;
521 (e) conflict of interest standards;

522 (f) exchange functions; and
523 (g) other requirements that may be adopted by the commissioner by administrative
524 rule.

525 (5) This section applies only to applicants who are natural persons.

526 Section 11. Section **31A-23b-206** is enacted to read:

527 **31A-23b-206. Continuing education requirements.**

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

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

532 (b) The commissioner may state a continuing education requirement in terms of hours
533 of instruction received in:

534 (i) accident and health insurance;

535 (ii) qualification for and enrollment in public programs;

536 (iii) qualification for and enrollment in premium subsidies;

537 (iv) cultural competency;

538 (v) conflict of interest standards; and

539 (vi) other exchange functions.

540 (3) (a) Continuing education requirements shall require:

541 (i) that a licensee complete 24 credit hours of continuing education for every two-year
542 licensing period;

543 (ii) that 3 of the 24 credit hours described in Subsection (3)(a)(i) be ethics courses; and

544 (iii) that the licensee complete at least half of the required hours through classroom
545 hours of insurance and exchange related instruction.

546 (b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be
547 obtained through:

548 (i) classroom attendance;

549 (ii) home study;

550 (iii) watching a video recording;

551 (iv) experience credit; or

552 (v) another method approved by rule.

553 (c) A licensee may obtain continuing education hours at any time during the two-year
554 license period.

555 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
556 commissioner shall, by rule:

557 (i) publish a list of insurance professional designations whose continuing education
558 requirements can be used to meet the requirements for continuing education under Subsection
559 (3)(b); and

560 (ii) authorize one or more continuing education providers, including a state or national
561 professional producer or consultant associations, to:

562 (A) offer a qualified program on a geographically accessible basis; and

563 (B) collect a reasonable fee for funding and administration of a continuing education
564 program, subject to the review and approval of the commissioner.

565 (4) The commissioner shall approve a continuing education provider or a continuing
566 education course that satisfies the requirements of this section.

567 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
568 commissioner shall by rule establish the procedures for continuing education provider
569 registration and course approval.

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

571 (7) A navigator shall keep documentation of completing the continuing education
572 requirements of this section for two years after the end of the two-year licensing period to
573 which the continuing education applies.

574 Section 12. Section **31A-23b-207** is enacted to read:

575 **31A-23b-207. Requirement to obtain surety bond.**

576 (1) (a) Except as provided in Subsections (1)(b)(ii) and (2), a navigator shall obtain a
577 surety bond in an amount designated by the commissioner by administrative rule to cover the
578 legal liability of the navigator as the result of an erroneous act or failure to act in the navigator's
579 capacity as a navigator.

580 (b) The navigator shall:

581 (i) maintain a surety bond at all times during the term of the navigator's license; or

582 (ii) demonstrate to the commissioner that the navigator is capable of covering a legal
583 liability for erroneous acts or failure to act in a manner approved by the commissioner.

584 (2) A navigator is not required to obtain and maintain a surety bond during a period in
585 which the navigator's scope of practice is limited to assisting individuals with:

- 586 (a) enrollment in public programs; and
587 (b) qualification for premium and cost sharing subsidies.

588 Section 13. Section **31A-23b-208** is enacted to read:

589 **31A-23b-208. Form and contents of license.**

590 (1) A license issued under this chapter shall be in the form the commissioner prescribes
591 and shall set forth:

- 592 (a) the name and address of the licensee;
593 (b) the date of license issuance; and
594 (c) any other information the commissioner considers necessary.

595 (2) A licensee under this chapter doing business under a name other than the licensee's
596 legal name shall notify the commissioner before using the assumed name in this state.

597 Section 14. Section **31A-23b-209** is enacted to read:

598 **31A-23b-209. Agency designations.**

599 (1) An organization shall be licensed as a navigator agency if the organization acts as a
600 navigator.

601 (2) A navigator agency that does business in the state shall designate an individual who
602 is licensed under this chapter to act on the agency's behalf.

603 (3) A navigator agency shall report to the commissioner, at intervals and in the form
604 the commissioner establishes by rule:

- 605 (a) a new designation under Subsection (2); and
606 (b) a terminated designation under Subsection (2).

607 (4) (a) A navigator agency licensed under this chapter shall report to the commissioner
608 the cause of termination of a designation if:

609 (i) the reason for termination is a reason described in Subsection 31A-23b-401(4)(b);

610 or

611 (ii) the navigator agency has knowledge that the individual licensee engaged in an
612 activity described in Subsection 31A-23b-401(4)(b) by:

- 613 (A) a court;
614 (B) a government body; or

615 (C) a self-regulatory organization, which the commissioner may define by rule made in
616 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

617 (b) The information provided to the commissioner under Subsection (4)(a) is a private
618 record under Title 63G, Chapter 2, Government Records Access and Management Act.

619 (c) A navigator agency is immune from civil action, civil penalty, or damages if the
620 agency complies in good faith with this Subsection (4) by reporting to the commissioner the
621 cause of termination of a designation.

622 (d) A navigator agency is not immune from an action or resulting penalty imposed on
623 the reporting agency as a result of proceedings brought by or on behalf of the department if the
624 action is based on evidence other than the report submitted in compliance with this Subsection
625 (4).

626 (5) A navigator agency licensed under this chapter may act in a capacity for which it is
627 licensed only through an individual who is licensed under this chapter to act in the same
628 capacity.

629 (6) A navigator agency licensed under this chapter shall designate and report to the
630 commissioner, in accordance with any rule made by the commissioner, the name of the
631 designated responsible licensed individual who has authority to act on behalf of the navigator
632 agency in the matters pertaining to compliance with this title and orders of the commissioner.

633 (7) If a navigator agency designates a licensee in reports submitted under Subsection
634 (3) or (6), there is a rebuttable presumption that the designated licensee acts on behalf of the
635 navigator agency.

636 (8) (a) When a license is held by a navigator agency, both the navigator agency itself
637 and any individual designated under the navigator agency license are considered the holders of
638 the navigator agency license for purposes of this section.

639 (b) If an individual designated under the navigator agency license commits an act or
640 fails to perform a duty that is a ground for suspending, revoking, or limiting the navigator
641 agency license, the commissioner may suspend, revoke, or limit the license of:

642 (i) the individual;

643 (ii) the navigator agency, if the navigator agency:

644 (A) is reckless or negligent in its supervision of the individual; or

645 (B) knowingly participates in the act or failure to act that is the ground for suspending,

646 revoking, or limiting the license; or

647 (iii) (A) the individual; and

648 (B) the navigator agency, if the agency meets the requirements of Subsection (8)(b)(ii).

649 Section 15. Section **31A-23b-210** is enacted to read:

650 **31A-23b-210. Place of business and residence address -- Records.**

651 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:

652 (i) the address and telephone numbers of the licensee's principal place of business; and

653 (ii) a valid business email address at which the commissioner may contact the licensee.

654 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the
655 individual shall register and maintain with the commissioner the individual's residence address

656 and telephone number.

657 (c) A licensee shall notify the commissioner within 30 days of a change of any of the
658 following required to be registered with the commissioner under this section:

659 (i) an address;

660 (ii) a telephone number; or

661 (iii) a business email address.

662 (2) Except as provided under Subsection (3), a licensee under this chapter shall keep at
663 the principal place of business address registered under Subsection (1), separate and distinct
664 books and records of the transactions consummated under the Utah license.

665 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
666 be obtained immediately from a central storage place or elsewhere by online computer
667 terminals located at the registered address.

668 (4) (a) The books and records maintained under Subsection (2) shall be available for
669 the inspection by the commissioner during the business hours for a period of time after the date
670 of the transaction as specified by the commissioner by rule, but in no case for less than the
671 current calendar year plus three years.

672 (b) Discarding books and records after the applicable record retention period has
673 expired does not place the licensee in violation of a later-adopted longer record retention
674 period.

675 Section 16. Section **31A-23b-211** is enacted to read:

676 **31A-23b-211. Exceptions to navigator licensing.**

- 677 (1) For purposes of this section:
- 678 (a) "Negotiate" is as defined in Section 31A-23a-102.
- 679 (b) "Sell" is as defined in Section 31A-23a-102.
- 680 (c) "Solicit" is as defined in Section 31A-23a-102.
- 681 (2) The commissioner may not require a license as a navigator of:
- 682 (a) a person who is employed by or contracts with:
- 683 (i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility
- 684 Licensing and Inspection Act, to assist an individual with enrollment in a public program or an
- 685 application for premium subsidy; or
- 686 (ii) the state, a political subdivision of the state, an entity of a political subdivision of
- 687 the state, or a public school district to assist an individual with enrollment in a public program
- 688 or an application for premium subsidy;
- 689 (b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social
- 690 Security Act which assists an individual with enrollment in a public program or an application
- 691 for premium subsidy;
- 692 (c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants,
- 693 and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to
- 694 sell, solicit, or negotiate accident and health insurance plans;
- 695 (d) an officer, director, or employee of a navigator:
- 696 (i) who does not receive compensation or commission from an insurer issuing an
- 697 insurance contract, an agency administering a public program, an individual who enrolled in a
- 698 public program or insurance product, or an exchange; and
- 699 (ii) whose activities:
- 700 (A) are executive, administrative, managerial, clerical, or a combination thereof;
- 701 (B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the
- 702 enrollment in a public program offered through the exchange;
- 703 (C) are in the capacity of a special agent or agency supervisor assisting an insurance
- 704 producer or navigator;
- 705 (D) are limited to providing technical advice and assistance to a licensed insurance
- 706 producer or navigator; or
- 707 (E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment

708 in a public program; and

709 (e) a person who does not sell, solicit, or negotiate insurance and is not directly or
710 indirectly compensated by an insurer issuing an insurance contract, an agency administering a
711 public program, an individual who enrolled in a public program or insurance product, or an
712 exchange, including:

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

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

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

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

722 (iii) an employee who counsels or advises the employee's employer with regard to the
723 insurance interests of the employer, or a subsidiary or business affiliate of the employer.

724 (3) The exemption from licensure under Subsections (2)(a) and (b) does not apply if a
725 person described in Subsections (2)(a) and (b) enrolls a person in a private insurance plan.

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

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

729 (i) special competence;

730 (ii) special trustworthiness; or

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

732 (b) other existing safeguards make regulation unnecessary.

733 Section 17. Section **31A-23b-301** is enacted to read:

734 **Part 3. Unlawful Conduct and Limitation of Scope of Practice**

735 **31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.**

736 (1) As used in this section, "false or misleading information" includes, with intent to
737 deceive a person examining it:

738 (a) filing a report;

- 739 (b) making a false entry in a record; or
740 (c) willfully refraining from making a proper entry in a record.
741 (2) (a) Communication that contains false or misleading information relating to
742 enrollment in an insurance plan or a public program, including information that is false or
743 misleading because it is incomplete, may not be made by:
744 (i) a person who is or should be licensed under this title;
745 (ii) an employee of a person described in Subsection (2)(a)(i);
746 (iii) a person whose primary interest is as a competitor of a person licensed under this
747 title; and
748 (iv) a person on behalf of any of the persons listed in this Subsection (2)(a).
749 (b) A licensee under this chapter may not:
750 (i) use any business name, slogan, emblem, or related device that is misleading or
751 likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental
752 agency, a PPACA exchange, insurer, or other licensee already in business; or
753 (ii) use any advertisement or other insurance promotional material that would cause a
754 reasonable person to mistakenly believe that a state or federal government agency, public
755 program, or insurer:
756 (A) is responsible for the insurance or public program enrollment assistance activities
757 of the person;
758 (B) stands behind the credit of the person; or
759 (C) is a source of payment of any insurance obligation of or sold by the person.
760 (c) A person who is not an insurer may not assume or use any name that deceptively
761 implies or suggests that person is an insurer.
762 (3) A person may not engage in an unfair method of competition or any other unfair or
763 deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
764 after a finding that the method of competition, the act, or the practice:
765 (a) is misleading;
766 (b) is deceptive;
767 (c) is unfairly discriminatory;
768 (d) provides an unfair inducement; or
769 (e) unreasonably restrains competition.

770 (4) A navigator licensed under this chapter is subject to the inducement provisions of
771 Section 31A-23a-402.5.

772 (5) A navigator licensed under this chapter or who should be licensed under this
773 chapter:

774 (a) may not receive direct or indirect compensation from an accident or health insurer
775 or from an individual who receives services from a navigator in accordance with:

776 (i) federal conflict of interest regulations established pursuant to PPACA; and

777 (ii) administrative rule adopted by the department;

778 (b) may be compensated by the exchange for performing the duties of a navigator;

779 (c) (i) may perform, offer to perform, or advertise a service as a navigator only for a
780 person selecting a qualified health plan or public program offered on an exchange; and

781 (ii) may not perform, offer to perform, or advertise any services as a navigator for
782 individuals or small employer groups selecting accident and health insurance plans, qualified
783 health plans, public programs, business, or services that are not offered on an exchange; and

784 (d) may not recommend a particular accident and health insurance plan or qualified
785 health plan.

786 Section 18. Section **31A-23b-401** is enacted to read:

787 **Part 4. License Denial and Discipline**

788 **31A-23b-401. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
789 **terminating a license -- Rulemaking for renewal or reinstatement.**

790 (1) A license as a navigator under this chapter remains in force until:

791 (a) revoked or suspended under Subsection (4);

792 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
793 administrative action;

794 (c) the licensee dies or is adjudicated incompetent as defined under:

795 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

796 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
797 Minors;

798 (d) lapsed under this section; or

799 (e) voluntarily surrendered.

800 (2) The following may be reinstated within one year after the day on which the license

801 is no longer in force:

802 (a) a lapsed license; or

803 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
804 not be reinstated after the license period in which the license is voluntarily surrendered.

805 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
806 license, submission and acceptance of a voluntary surrender of a license does not prevent the
807 department from pursuing additional disciplinary or other action authorized under:

808 (a) this title; or

809 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
810 Administrative Rulemaking Act.

811 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
812 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
813 commissioner may:

814 (i) revoke a license;

815 (ii) suspend a license for a specified period of 12 months or less;

816 (iii) limit a license in whole or in part; or

817 (iv) deny a license application.

818 (b) The commissioner may take an action described in Subsection (4)(a) if the
819 commissioner finds that the licensee:

820 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
821 31A-23b-206;

822 (ii) violated:

823 (A) an insurance statute;

824 (B) a rule that is valid under Subsection 31A-2-201(3); or

825 (C) an order that is valid under Subsection 31A-2-201(4);

826 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
827 delinquency proceedings in any state;

828 (iv) failed to pay a final judgment rendered against the person in this state within 60
829 days after the day on which the judgment became final;

830 (v) refused:

831 (A) to be examined; or

- 832 (B) to produce its accounts, records, and files for examination;
833 (vi) had an officer who refused to:
834 (A) give information with respect to the navigator's affairs; or
835 (B) perform any other legal obligation as to an examination;
836 (vii) provided information in the license application that is:
837 (A) incorrect;
838 (B) misleading;
839 (C) incomplete; or
840 (D) materially untrue;
841 (viii) violated an insurance law, valid rule, or valid order of another state's insurance
842 department;
843 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
844 (x) improperly withheld, misappropriated, or converted money or properties received
845 in the course of doing insurance business;
846 (xi) intentionally misrepresented the terms of an actual or proposed:
847 (A) insurance contract;
848 (B) application for insurance; or
849 (C) application for public program;
850 (xii) is convicted of a felony;
851 (xiii) admitted or is found to have committed an insurance unfair trade practice or
852 fraud;
853 (xiv) in the conduct of business in this state or elsewhere:
854 (A) used fraudulent, coercive, or dishonest practices; or
855 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
856 (xv) had an insurance license, navigator license, or its equivalent, denied, suspended,
857 or revoked in another state, province, district, or territory;
858 (xvi) forged another's name to:
859 (A) an application for insurance;
860 (B) a document related to an insurance transaction;
861 (C) a document related to an application for a public program; or
862 (D) a document related to an application for premium subsidies;

863 (xvii) improperly used notes or another reference material to complete an examination
864 for a license;

865 (xviii) knowingly accepted insurance business from an individual who is not licensed;

866 (xix) failed to comply with an administrative or court order imposing a child support
867 obligation;

868 (xx) failed to:

869 (A) pay state income tax; or

870 (B) comply with an administrative or court order directing payment of state income

871 tax;

872 (xxi) violated or permitted others to violate the federal Violent Crime Control and Law
873 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
874 prohibited from engaging in the business of insurance; or

875 (xxii) engaged in a method or practice in the conduct of business that endangered the
876 legitimate interests of customers and the public.

877 (c) For purposes of this section, if a license is held by an agency, both the agency itself
878 and any individual designated under the license are considered to be the holders of the license.

879 (d) If an individual designated under the agency license commits an act or fails to
880 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
881 the commissioner may suspend, revoke, or limit the license of:

882 (i) the individual;

883 (ii) the agency, if the agency:

884 (A) is reckless or negligent in its supervision of the individual; or

885 (B) knowingly participates in the act or failure to act that is the ground for suspending,
886 revoking, or limiting the license; or

887 (iii) (A) the individual; and

888 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

889 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
890 without a license if:

891 (a) the licensee's license is:

892 (i) revoked;

893 (ii) suspended;

894 (iii) surrendered in lieu of administrative action;

895 (iv) lapsed; or

896 (v) voluntarily surrendered; and

897 (b) the licensee:

898 (i) continues to act as a licensee; or

899 (ii) violates the terms of the license limitation.

900 (6) A licensee under this chapter shall immediately report to the commissioner:

901 (a) a revocation, suspension, or limitation of the person's license in another state, the

902 District of Columbia, or a territory of the United States;

903 (b) the imposition of a disciplinary sanction imposed on that person by another state,

904 the District of Columbia, or a territory of the United States; or

905 (c) a judgment or injunction entered against that person on the basis of conduct

906 involving:

907 (i) fraud;

908 (ii) deceit;

909 (iii) misrepresentation; or

910 (iv) a violation of an insurance law or rule.

911 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a

912 license in lieu of administrative action may specify a time, not to exceed five years, within

913 which the former licensee may not apply for a new license.

914 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the

915 former licensee may not apply for a new license for five years from the day on which the order

916 or agreement is made without the express approval of the commissioner.

917 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of

918 a license issued under this chapter if so ordered by a court.

919 (9) The commissioner shall by rule prescribe the license renewal and reinstatement

920 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

921 Section 19. Section **31A-23b-402** is enacted to read:

922 **31A-23b-402. Probation -- Grounds for revocation.**

923 (1) The commissioner may place a licensee on probation for a period not to exceed 24

924 months as follows:

925 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
926 Procedures Act, for any circumstances that would justify a suspension under this section; or

927 (b) at the issuance of a new license:

928 (i) with an admitted violation under 18 U.S.C. Secs. 1033 and 1034; or

929 (ii) with a response to background information questions on a new license application
930 indicating that:

931 (A) the person has been convicted of a crime that is listed by rule made in accordance
932 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for
933 probation;

934 (B) the person is currently charged with a crime that is listed by rule made in
935 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
936 a ground for probation regardless of whether adjudication is withheld;

937 (C) the person has been involved in an administrative proceeding regarding any
938 professional or occupational license; or

939 (D) any business in which the person is or was an owner, partner, officer, or director
940 has been involved in an administrative proceeding regarding any professional or occupational
941 license.

942 (2) The commissioner may place a licensee on probation for a specified period no
943 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. Secs. 1033
944 and 1034.

945 (3) The probation order shall state the conditions for revocation or retention of the
946 license, which shall be reasonable.

947 (4) Any violation of the probation is a ground for revocation pursuant to any
948 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

949 Section 20. Section **31A-23b-403** is enacted to read:

950 **31A-23b-403. License lapse and voluntary surrender.**

951 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:

952 (i) pay when due a fee under Section 31A-3-103;

953 (ii) complete continuing education requirements under Section 31A-23b-206 before
954 submitting the license renewal application;

955 (iii) submit a completed renewal application as required by Section 31A-23b-203;

956 (iv) submit additional documentation required to complete the licensing process; or
957 (v) maintain an active license in a resident state if the licensee is a nonresident
958 licensee.

959 (b) (i) A licensee whose license lapses due to the following may request an action
960 described in Subsection (1)(b)(ii):

961 (A) military service;

962 (B) voluntary service for a period of time designated by the person for whom the
963 licensee provides voluntary service; or

964 (C) other extenuating circumstances, including long-term medical disability.

965 (ii) A licensee described in Subsection (1)(b)(i) may request:

966 (A) reinstatement of the license no later than one year after the day on which the
967 license lapses; and

968 (B) waiver of any of the following imposed for failure to comply with renewal
969 procedures:

970 (I) an examination requirement;

971 (II) reinstatement fees set under Section 31A-3-103;

972 (III) continuing education requirements; or

973 (IV) other sanctions imposed for failure to comply with renewal procedures.

974 (2) If a license issued under this chapter is voluntarily surrendered, the license may be
975 reinstated:

976 (a) during the license period in which the license is voluntarily surrendered; and

977 (b) no later than one year after the day on which the license is voluntarily surrendered.

978 (3) A voluntarily surrendered license that is reinstated during the license period set
979 forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the
980 license complies with any applicable continuing education requirements for the period during
981 which the license was voluntarily surrendered.

982 Section 21. Section **31A-23b-404** is enacted to read:

983 **31A-23b-404. Penalties.**

984 (1) (a) If, after notice and opportunity to be heard, the commissioner finds that the
985 navigator or any other person has not materially complied with this part, or any rule made or
986 order issued under this chapter, the commissioner may order the navigator or other person to

987 cease doing business in the state.

988 (b) If the commissioner finds that because of the material noncompliance an insurer,
989 any policyholder of an insurer, or a recipient of a public program who used the services of the
990 navigator or other person has suffered any loss or damage due to the material noncompliance,
991 the commissioner may:

992 (i) maintain a civil action or may intervene in an action brought by or on behalf of the
993 insurer, policyholder, or the recipient of the public program, for recovery of compensatory
994 damages for the benefit of the insurer, policyholder, or recipient of a public program; or

995 (ii) seek other appropriate relief.

996 (2) Nothing in this section affects the right of the commissioner to impose any other
997 penalties provided for in this title.

998 (3) Nothing contained in this section is intended to or shall in any manner alter or
999 affect the rights of policyholders, claimants, creditors, or other third parties.

1000 Section 22. Section **31A-30-104** is amended to read:

1001 **31A-30-104. Applicability and scope.**

1002 (1) This chapter applies to any:

1003 (a) health benefit plan that provides coverage to:

1004 (i) individuals;

1005 (ii) small employers; or

1006 (iii) both Subsections (1)(a)(i) and (ii); or

1007 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
1008 31A-30-107.5.

1009 (2) This chapter applies to a health benefit plan that provides coverage to small
1010 employers or individuals regardless of:

1011 (a) whether the contract is issued to:

1012 (i) an association;

1013 (ii) a trust;

1014 (iii) a discretionary group; or

1015 (iv) other similar grouping; or

1016 (b) the situs of delivery of the policy or contract.

1017 (3) This chapter does not apply to:

1018 (a) short-term limited duration health insurance; or

1019 (b) federally funded or partially funded programs.

1020 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

1021 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
1022 return shall be treated as one carrier; and

1023 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
1024 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
1025 carriers were issued by one carrier.

1026 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
1027 maintenance organization having a certificate of authority under this title may be considered to
1028 be a separate carrier for the purposes of this chapter.

1029 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
1030 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
1031 arrangements with respect to health benefit plans delivered or issued for delivery to covered
1032 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
1033 obligation or risk for the health benefit plans being retained by the ceding carrier.

1034 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
1035 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
1036 for delivery to covered insureds in this state.

1037 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
1038 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
1039 may make a written request to the commissioner for a waiver from the application of any of the
1040 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
1041 trust.

1042 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
1043 waiver if the commissioner finds that application with respect to the trust would:

1044 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
1045 and

1046 (ii) require significant modifications to one or more collective bargaining arrangements
1047 under which the trust is established or maintained.

1048 (c) A waiver granted under this Subsection (5) may not apply to an individual if the

1049 person participates in a Taft Hartley trust as an associate member of any employee
1050 organization.

1051 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
1052 31A-30-111 apply to:

1053 (a) any insurer engaging in the business of insurance related to the risk of a small
1054 employer for medical, surgical, hospital, or ancillary health care expenses of the small
1055 employer's employees provided as an employee benefit; and

1056 (b) any contract of an insurer, other than a workers' compensation policy, related to the
1057 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
1058 small employer's employees provided as an employee benefit.

1059 (7) The commissioner may make rules requiring that the marketing practices be
1060 consistent with this chapter for:

1061 (a) a small employer carrier;

1062 (b) a small employer carrier's agent;

1063 (c) an insurance producer; ~~and~~

1064 (d) an insurance consultant; and

1065 (e) a navigator.

1066 Section 23. Section **31A-30-105** is amended to read:

1067 **31A-30-105. Establishment of classes of business.**

1068 [~~(1) For a policy that takes effect on or after January 1, 2011~~] Effective January 1,
1069 2014, a covered carrier may [~~not~~] establish [~~a separate class~~] up to four separate classes of
1070 business [~~unless~~]:

1071 [~~(a) the covered carrier submits an application to the commissioner to establish a~~
1072 ~~separate class of business;~~]

1073 [~~(b) the covered carrier demonstrates to the satisfaction of the commissioner that a~~
1074 ~~separate class of business is justified under the provisions of this section; and]~~

1075 [~~(c) the commissioner approves the carrier's application for the use of a separate class~~
1076 ~~of business.~~]

1077 [~~(2)(a) The commissioner shall have a presumption against the use of a separate class~~
1078 ~~of business by a covered insured, except when the covered carrier demonstrates that this~~
1079 ~~Subsection (2) applies.~~]

1080 ~~[(b) The commissioner may approve the use of a separate class of business only if the~~
 1081 ~~covered carrier can demonstrate that the use of a separate class of business is necessary due to~~
 1082 ~~substantial differences in either expected claims experience or administrative costs related to~~
 1083 ~~the following reasons:]~~

1084 ~~[(i) the covered carrier uses more than one type of system for the marketing and sale of~~
 1085 ~~health benefit plans to covered insureds;]~~

1086 ~~[(ii) the covered carrier has acquired a class of business from another covered carrier;~~
 1087 ~~or]~~

1088 ~~[(iii) the covered carrier provides coverage to one or more association groups.]~~

1089 ~~[(3) The commissioner may establish regulations to provide for a period of transition in~~
 1090 ~~order for a covered carrier to come into compliance with Subsection (2) in the instance of~~
 1091 ~~acquisition of an additional class of business from another covered carrier.]~~

1092 ~~[(4) The commissioner may approve the establishment of up to five classes of business~~
 1093 ~~per covered carrier upon application to the commissioner and a finding by the commissioner~~
 1094 ~~that such action would substantially enhance the efficiency and fairness of the health insurance~~
 1095 ~~marketplace subject to this chapter.]~~

1096 ~~[(5) A covered carrier may not establish a class of business based solely on the~~
 1097 ~~marketing or sale of a health benefit plan as a defined contribution arrangement health benefit~~
 1098 ~~plan, or through the Health Insurance Exchange.]~~

1099 (1) one class of business for individual health benefit plans that are not grandfathered
 1100 under PPACA;

1101 (2) one class of business for small employer health benefit plans that are not
 1102 grandfathered under PPACA;

1103 (3) one class of business for individual health benefit plans that are grandfathered
 1104 under PPACA; and

1105 (4) one class of business for small employer health benefit plans that are grandfathered
 1106 under PPACA.

1107 Section 24. Section **31A-30-107.3** is amended to read:

1108 **31A-30-107.3. Discontinuance and nonrenewal limitations and conditions.**

1109 (1) ~~[(a)]~~ A carrier that elects to discontinue offering ~~[a]~~ all individual health benefit
 1110 ~~[plan]~~ plans under Subsection ~~[31A-30-107(3)(e) or]~~ 31A-30-107.1(3)(e) is prohibited from

1111 writing new business[:(i) in the small employer and] in the individual market in this state[-; and
1112 (ii)] for a period of five years beginning on the date of discontinuation of the last individual
1113 health benefit plan coverage that is discontinued.

1114 [~~(b)~~ The prohibition described in Subsection (1)(a) may be waived if the commissioner
1115 finds that waiver is in the public interest:]

1116 [(i) to promote competition; or]

1117 [(ii) to resolve inequity in the marketplace.]

1118 (2) A carrier that elects to discontinue offering all small employer health benefit plans
1119 under Subsection 31A-30-107(3)(e) is prohibited from writing new business in the small group
1120 market in this state for a period of five years beginning on the date of discontinuation of the
1121 last small employer coverage that is discontinued.

1122 [~~(2)~~] (3) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A,
1123 Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if
1124 enrollment is capped or suspended, an individual carrier:

1125 (i) may, except as prohibited by Section 31A-30-117, elect to discontinue offering new
1126 individual health benefit plans, except to HIPAA eligibles, but shall keep existing individual
1127 health benefit plans in effect, except those individual plans that are not renewed under the
1128 provisions of Subsection 31A-30-107(2) or 31A-30-107.1(2);

1129 (ii) may elect to continue to offer new individual and small employer health benefit
1130 plans; or

1131 (iii) may elect to discontinue all of the covered carrier's health benefit plans in the
1132 individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or
1133 31A-30-107.1(3)(e).

1134 (b) A carrier that makes an election under Subsection [~~(2)~~] (3)(a)(i):

1135 (i) is prohibited from writing new business:

1136 (A) in the individual market in this state; and

1137 (B) for a period of five years beginning on the date of discontinuation;

1138 (ii) may continue to write new business in the small employer market; and

1139 (iii) shall provide written notice of the election under Subsection [~~(2)~~] (3)(a)(i) within
1140 two calendar days of the election to the Utah Insurance Department.

1141 (c) The prohibition described in Subsection [~~(2)~~] (3)(b)(i) may be waived if the

1142 commissioner finds that waiver is in the public interest:

1143 (i) to promote competition; or

1144 (ii) to resolve inequity in the marketplace.

1145 (d) A carrier that makes an election under Subsection ~~[(2)]~~ (3)(a)(iii) is subject to the
1146 provisions of Subsection (1).

1147 ~~[(3)]~~ (4) If a carrier is doing business in one established geographic service area of the
1148 state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that
1149 geographic service area.

1150 ~~[(4)]~~ (5) If a small employer employs less than two eligible employees, a carrier may
1151 not discontinue or not renew the health benefit plan until the first renewal date following the
1152 beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that
1153 the employer no longer has at least two current employees.

1154 Section 25. Section **31A-30-112** is amended to read:

1155 **31A-30-112. Employee participation levels.**

1156 (1) (a) For purposes of this section, "participation" is as defined in Section 31A-1-301.

1157 ~~[(1)-(a)]~~ (b) Except as provided in Subsection (2) and Section 31A-30-206, a
1158 requirement used by a covered carrier in determining whether to provide coverage to a small
1159 employer, including a participation requirement ~~[for minimum participation of eligible~~
1160 ~~employees]~~ and a minimum employer ~~[contributions]~~ contribution requirement, shall be
1161 applied uniformly among all small employers with the same number of eligible employees
1162 applying for coverage or receiving coverage from the covered carrier.

1163 ~~[(b) In addition to applying Subsection 31A-1-301(124), a covered carrier may require~~
1164 ~~that a small employer have a minimum of two eligible employees to meet participation~~
1165 ~~requirements.]~~

1166 (2) A covered carrier may not increase a ~~[requirement for minimum employee]~~
1167 participation requirement or a requirement for minimum employer contribution, applicable to a
1168 small employer, at any time after the small employer is accepted for coverage.

1169 Section 26. Section **31A-30-115** is amended to read:

1170 **31A-30-115. Actuarial review of health benefit plans.**

1171 (1) (a) The department shall conduct an actuarial review of rates submitted by ~~[small~~
1172 ~~employer carriers]~~ a carrier that offers a small employer plan and a carrier that offers an

1173 individual plan under this chapter:

1174 ~~[(i) prior to the publication of the premium rates on the Health Insurance Exchange;]~~

1175 ~~[(ii) except as permitted by Subsection 31A-30-207(2), to determine if the carrier is~~
1176 ~~using the same rating and underwriting practices in both the defined contribution arrangement~~
1177 ~~market in the Health Insurance Exchange and the defined benefit market offered outside the~~
1178 ~~Health Insurance Exchange, in compliance with Subsection 31A-30-202.5(1)(b);]~~

1179 ~~[(iii) to verify the validity of the rates, underwriting and risk factors, and premiums of~~
1180 ~~plans both in and outside of the Health Insurance Exchange;]~~

1181 ~~[(iv) to verify that insurers are pricing similar health benefit plans and groups the same~~
1182 ~~in and out of the exchange, except as permitted by Subsection 31A-30-207(2); and]~~

1183 (i) to verify the validity of the rates, risk factors, and premiums of the plans; and

1184 ~~[(v)]~~ (ii) as the department determines is necessary to oversee market conduct.

1185 (b) The actuarial review by the department shall be funded from a fee:

1186 (i) established by the department in accordance with Section 63J-1-504; and

1187 (ii) paid by ~~[all small employer carriers participating in the defined contribution~~
1188 ~~arrangement market and small employer carriers offering health benefit plans under Part 1,~~
1189 ~~Individual and Small Employer Group]~~ a carrier offering a health benefit plan subject to this
1190 chapter.

1191 (c) The department shall:

1192 (i) report aggregate data from the actuarial review to the risk adjuster board created in
1193 Section 31A-42-201; and

1194 (ii) contact carriers, if the department determines it is appropriate, to:

1195 (A) inform a carrier of the department's findings regarding the rates of a particular
1196 carrier; and

1197 (B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

1198 (d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

1199 (2) (a) There is created in the General Fund a restricted account known as the "Health
1200 Insurance Actuarial Review Restricted Account."

1201 (b) The Health Insurance Actuarial Review Restricted Account shall consist of money
1202 received by the commissioner under this section.

1203 (c) The commissioner shall administer the Health Insurance Actuarial Review

1204 Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use
1205 money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the
1206 actuarial review conducted by the department under this section.

1207 Section 27. Section **31A-30-117** is enacted to read:

1208 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**

1209 (1) (a) After complying with the reporting requirements of Section 63M-1-2505.5, the
1210 commissioner may adopt administrative rules that change the rating and underwriting
1211 requirements of this chapter as necessary to transition the insurance market to meet federal
1212 qualified health plan standards and rating practices under PPACA.

1213 (b) Administrative rules adopted by the commissioner under this section may include:

1214 (i) the regulation of health benefit plans as described in Subsections 31A-2-212(5)(a)
1215 and (b); and

1216 (ii) disclosure of records and information required by PPACA and state law.

1217 (c) (i) The commissioner shall establish by administrative rule one statewide open
1218 enrollment period that applies to the individual insurance market that is not on the PPACA
1219 certified individual exchange.

1220 (ii) The statewide open enrollment period:

1221 (A) may be shorter, but no longer than the open enrollment period established for the
1222 individual insurance market offered in the PPACA certified exchange; and

1223 (B) may not be extended beyond the dates of the open enrollment period established
1224 for the individual insurance market offered in the PPACA certified exchange.

1225 (2) A carrier that offers health benefit plans in the individual market that is not part of
1226 the individual PPACA certified exchange:

1227 (a) shall open enrollment:

1228 (i) during the statewide open enrollment period established in Subsection (1)(c); and

1229 (ii) at other times, for qualifying events, as determined by administrative rule adopted
1230 by the commissioner; and

1231 (b) may open enrollment at any time.

1232 (3) (a) The commissioner shall identify a new mandated benefit that is in excess of the
1233 essential health benefits required by PPACA.

1234 (b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to

1235 defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c)
1236 directly to the qualified health plan issuer on behalf of an individual who receives an advance
1237 premium tax credit under PPACA.

1238 (c) The state shall quantify the cost attributable to each additional mandated benefit
1239 specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost
1240 associated with the mandated benefit, which shall be:

1241 (i) calculated in accordance with generally accepted actuarial principles and
1242 methodologies;

1243 (ii) conducted by a member of the American Academy of Actuaries; and

1244 (iii) reported to the commissioner and to the individual exchange operating in the state.

1245 (d) The commissioner may require a proponent of a new mandated benefit under
1246 Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance
1247 with Subsection (3)(c). The commissioner may use the cost information provided under this
1248 Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under
1249 Subsection (3)(b).

1250 Section 28. Section **31A-30-202.6** is enacted to read:

1251 **31A-30-202.6. Dental and vision plans on the defined contribution arrangement**
1252 **market.**

1253 (1) Beginning January 1, 2014, a carrier may offer dental and vision plans in the
1254 defined contribution arrangement market.

1255 (2) (a) A carrier that offers a dental or vision plan in the defined contribution
1256 arrangement market is not required to offer the same dental or vision plans outside the defined
1257 contribution arrangement market and does not have to use the same rating and underwriting
1258 practices in and out of the defined contribution arrangement market.

1259 (b) If a carrier offers a dental or vision plan in the defined contribution arrangement
1260 market, the carrier shall allow an employee of a small employer group to enroll in a dental and
1261 vision plan in accordance with Subsection (3).

1262 (3) (a) A small employer group shall participate in a defined contribution arrangement
1263 and meet participation requirements for the defined contribution arrangement before the
1264 employer may elect to offer its employees dental or vision plans under Subsection (3)(b).

1265 (b) A small employer who meets the requirements of Subsection (3)(a) may elect to

1266 offer its employees:

1267 (i) a dental plan offered in the defined contribution arrangement market;

1268 (ii) a vision plan offered in the defined contribution arrangement market; or

1269 (iii) both a vision plan and a dental plan offered in the defined contribution

1270 arrangement market.

1271 (4) An employee whose employer has offered its employees a defined contribution

1272 medical plan and met participation requirements under Subsection (3)(a) may elect to enroll, or

1273 not enroll, in the dental and vision plan selected by the employer.

1274 (5) An employer's small group must meet participation requirements established by the

1275 commissioner by administrative rule for each dental or vision plan selected by an employer

1276 under Subsection (3).

1277 Section 29. Section **31A-30-208** is amended to read:

1278 **31A-30-208. Enrollment for defined contribution arrangements.**

1279 (1) An insurer offering a health benefit plan in the defined contribution arrangement

1280 market:

1281 (a) shall allow an employer to enroll in a small employer defined contribution

1282 arrangement plan; and

1283 ~~[(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer~~

1284 ~~group selecting a defined contribution arrangement health benefit plan on or before January 1,~~

1285 ~~2012; and]~~

1286 ~~[(c)]~~ (b) shall otherwise comply with the requirements of this part, Chapter 42, Defined

1287 Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

1288 (2) (a) ~~[Except as provided in Subsection 31A-30-202.5(2), in accordance with~~

1289 ~~Subsection (2)(b), on January 1 of each year, an]~~ An insurer may enter or exit the defined

1290 contribution arrangement market on January 1 of each year.

1291 (b) An insurer may offer new or modify existing products in the defined contribution

1292 arrangement market:

1293 (i) on January 1 of each year;

1294 (ii) when required by changes in other law; and

1295 (iii) at other times as established by the risk adjuster board created in Section

1296 31A-42-201.

1297 (c) [(†)] An insurer shall give the department, the Health Insurance Exchange, and the
1298 risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a)
1299 or (b).

1300 [~~(ii) When an insurer elects to participate in the defined contribution arrangement~~
1301 ~~market, the insurer shall participate in the defined contribution arrangement market for no less~~
1302 ~~than two years.]~~

1303 Section 30. Section **31A-43-101** is enacted to read:

1304 **CHAPTER 43. SMALL EMPLOYER STOP-LOSS INSURANCE ACT**

1305 **Part 1. General Provisions**

1306 **31A-43-101. Title.**

1307 This chapter is known as the "Small Employer Stop-Loss Insurance Act."

1308 Section 31. Section **31A-43-102** is enacted to read:

1309 **31A-43-102. Definitions.**

1310 For purposes of this chapter:

1311 (1) "Actuarial certification" means a written statement by a member of the American
1312 Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer
1313 is in compliance with the provisions of this chapter, based upon the individual's examination
1314 and including a review of the appropriate records and the actuarial assumptions and methods
1315 used by the stop-loss insurer in establishing attachment points and other applicable
1316 determinations in conjunction with the provision of stop-loss insurance coverage.

1317 (2) "Aggregate attachment point" means the dollar amount in losses for eligible
1318 expenses incurred by a small employer plan beyond which the stop-loss insurer incurs liability
1319 for all or part of the losses incurred by the small employer plan, subject to limitations included
1320 in the contract.

1321 (3) "Coverage" means the combination of the employer plan design and the stop-loss
1322 contract design.

1323 (4) "Expected claims" means the amount of claims that, in the absence of a stop-loss
1324 contract, are projected to be incurred by a small employer health plan using reasonable and
1325 accepted actuarial principles.

1326 (5) "Lasering":

1327 (a) means increasing or removing stop-loss coverage for a specific individual within an

1328 employer group; and

1329 (b) includes other practices that are prohibited by the commissioner by administrative
1330 rule that result in lowering the stop-loss premium for the employer by transferring the risk for
1331 an individual.

1332 (6) "Small employer" means an employer who, with respect to a calendar year and to a
1333 plan year:

1334 (a) employed an average of at least two employees but not more than 50 eligible
1335 employees on each business day during the preceding calendar year; and

1336 (b) employs at least two employees on the first day of the plan year.

1337 (7) "Specific attachment point" means the dollar amount in losses for eligible expenses
1338 attributable to a single individual covered by a small employer plan in a contract year beyond
1339 which the stop-loss insurer assumes all or part of the liability for losses incurred by the small
1340 employer plan, subject to limitations included in the contract.

1341 (8) "Stop-loss insurance" means insurance purchased by a small employer for which
1342 the stop-loss insurer assumes, on a per-loss basis, all loss amounts of the small employer's plan
1343 in excess of a stated amount, subject to the policy limit.

1344 Section 32. Section **31A-43-201** is enacted to read:

1345 **Part 2. Scope of Chapter**

1346 **31A-43-201. Scope of chapter.**

1347 (1) This chapter establishes criteria for the issuance of stop-loss insurance contracts or
1348 re-insurance contracts for small employers that establish self-funded or partially self-funded
1349 health plans for the small employer's employees. This chapter does not:

1350 (a) impose any requirement or duty on any person other than a stop-loss insurer or
1351 re-insurer who issues a stop-loss insurance contract to a small employer;

1352 (b) treat any stop-loss insurance contract as a direct policy of health insurance; or

1353 (c) constitute an attempt to exercise authority over self-funded or partially self-funded
1354 health benefit plans sponsored by a small employer.

1355 (2) This chapter applies to a small employer stop-loss contract issued or renewed on or
1356 after July 1, 2013.

1357 Section 33. Section **31A-43-202** is enacted to read:

1358 **31A-43-202. Laws applicable to stop-loss insurance.**

1359 A stop-loss insurance contract or a re-insurance contract issued to a small employer that
1360 establishes a self-funded or partially self-funded health plan:

1361 (1) is not reinsurance under this title, and is not subject to the regulations for
1362 reinsurance under this title;

1363 (2) is subject to regulation as stop-loss insurance under this chapter; and

1364 (3) is subject to the contract provisions of this title in the same manner as insurance
1365 contracts issued by any other insurer.

1366 Section 34. Section **31A-43-301** is enacted to read:

1367 **Part 3. Stop-loss Insurance**

1368 **31A-43-301. Stop-loss insurance coverage standards.**

1369 (1) A small employer stop-loss insurance contract shall:

1370 (a) be issued to the small employer to provide insurance to the group health benefit
1371 plan, not the employees of the small employer;

1372 (b) use a standard application form developed by the commissioner by administrative
1373 rule;

1374 (c) have a contract term with guaranteed rates for at least 12 months, without
1375 adjustment, unless there is a change in the benefits provided under the small employer's health
1376 plan during the contract period;

1377 (d) include both a specific attachment point and an aggregate attachment point in a
1378 contract;

1379 (e) align stop-loss plan benefit limitations and exclusions with a small employer's
1380 health plan benefit limitations and exclusions, including any annual or lifetime limits in the
1381 employer's health plan;

1382 (f) have an annual specific attachment point that is at least \$10,000;

1383 (g) have an annual aggregate attachment point that may not be less than 90% of
1384 expected claims;

1385 (h) pay stop-loss claims:

1386 (i) incurred during the contract period; and

1387 (ii) submitted within 12 months after the expiration date of the contract; and

1388 (i) include provisions to cover incurred and unpaid claims if a small employer plan
1389 terminates.

1390 (2) A small employer stop-loss contract shall not:

1391 (a) include lasering; and

1392 (b) pay claims directly to an individual employee, member, or participant.

1393 Section 35. Section **31A-43-302** is enacted to read:

1394 **31A-43-302. Stop-loss restrictions -- Filing requirements.**

1395 (1) A stop-loss insurer shall demonstrate to the commissioner that the ~~H~~→ **rates associated**

1395a with ~~H~~ specific and

1396 aggregate attachment points retained by a small employer group under the insurer's stop-loss

1397 plan are actuarially sound.

1398 (2) A stop-loss insurer shall file the stop-loss insurance contract form and rates with

1399 the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss

1400 insurance contract may be issued or delivered in the state.

1401 (3) A stop-loss insurer shall file with the commissioner, annually on or before April 1,

1402 in a form and manner required by the commissioner by administrative rule adopted by the

1403 commissioner:

1404 (a) an actuarial memorandum and certification which demonstrates that the insurer is in

1405 compliance with this chapter; and

1406 (b) the stop-loss insurer's stop-loss experience.

1407 (4) Each insurer shall maintain at its principal place of business:

1408 (a) a complete and detailed description of its rating practices and renewal underwriting

1409 practices, including information and documentation that demonstrate the rating methods and

1410 practices are:

1411 (i) based upon commonly accepted actuarial assumptions; and

1412 (ii) in accordance with sound actuarial principles; and

1413 (b) a copy of the actuarial certification required by Subsection (3).

1414 Section 36. Section **31A-43-303** is enacted to read:

1415 **31A-43-303. Stop-loss insurance disclosure.**

1416 A stop-loss insurance contract delivered, issued for delivery, or entered into shall

1417 include the disclosure exhibit required by the ~~H~~→ **[commission]** commissioner ~~H~~ through

1417a administrative rule ~~S~~→ [~~The~~

1418 disclosure shall clearly describe] ,which shall include at least the following information ~~S~~ :

1419 (1) the complete costs for the stop-loss contract;

1420 (2) the date on which the insurance takes effect and terminates, including renewability

1421 provisions:

1422 (3) the aggregate attachment point and the specific attachment point: ~~§~~ → [and] ← ~~§~~

1423 (4) any limitations on coverage ~~§~~ → ;

1423a (5) an explanation of monthly accommodation and disclosure about any monthly
 1423b accommodation features included in the stop-loss contract; and

1423c (6) a description of terminal liability funding, including:

1423d (a) cost of processing claims before and after the termination of the contract; and

1423e (b) maximum claims liability to the employer ← ~~§~~ .

1424 Section 37. Section **31A-43-304** is enacted to read:

1425 **31A-43-304. Administrative rules.**

1426 The commissioner may adopt administrative rules in accordance with Title 63G,

1427 Chapter 3, Utah Administrative Rulemaking Act, to:

1428 (1) implement this chapter;

1429 (2) assure that differences in rates charged are reasonable and reflect objective

1430 differences in plan design;

1431 (3) define lasering practices that are prohibited by this chapter;

1432 (4) establish the form and manner of the actuarial certification and the annual report on
 1433 stop-loss experience required by Section 31A-43-302;

1434 (5) establish the form and manner of the disclosure required by Section 31A-43-303;

1435 (6) assure the ~~Ĥ~~ → [levels of] rates associated with the ← ~~Ĥ~~ specific attachment points and
 1435a aggregate attachment points

1436 ~~Ĥ~~ → [retained by the small employer plans] ← ~~Ĥ~~ are actuarially sound and are not against the public
 1437 interest; and

1438 (7) assure that stop-loss contracts include provisions to cover incurred and unpaid

1439 claims if a small employer plan terminates.

1440 Section 38. Section **63I-2-231 (Superseded 07/01/13)** is amended to read:

1441 **63I-2-231 (Superseded 07/01/13). Repeal dates, Title 31A.**

1442 Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed July 1,
 1443 [2013] 2015.

1444 Section 39. Section **63I-2-231 (Effective 07/01/13)** is amended to read:

1445 **63I-2-231 (Effective 07/01/13). Repeal dates, Title 31A.**

1446 (1) Section 31A-22-315.5 is repealed July 1, 2016.

1447 (2) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed July 1,
 1448 [2013] 2015.

1449 Section 40. Section **63M-1-2505.5** is amended to read:

1450 **63M-1-2505.5. Reporting on federal health reform -- Prohibition of individual**
 1451 **mandate.**

- 1452 (1) The Legislature finds that:
- 1453 (a) the state has embarked on a rigorous process of implementing a strategic plan for
- 1454 health system reform pursuant to Section 63M-1-2505;
- 1455 (b) the health system reform efforts for the state were developed to address the unique
- 1456 circumstances within Utah and to provide solutions that work for Utah;
- 1457 (c) Utah is a leader in the nation for health system reform which includes:
- 1458 (i) developing and using health data to control costs and quality; and
- 1459 (ii) creating a defined contribution insurance market to increase options for employers
- 1460 and employees; and
- 1461 (d) the federal government proposals for health system reform:
- 1462 (i) infringe on state powers;
- 1463 (ii) impose a uniform solution to a problem that requires different responses in
- 1464 different states;
- 1465 (iii) threaten the progress Utah has made towards health system reform; and
- 1466 (iv) infringe on the rights of citizens of this state to provide for their own health care
- 1467 by:
- 1468 (A) requiring a person to enroll in a third party payment system;
- 1469 (B) imposing fines, penalties, and taxes on a person who chooses to pay directly for
- 1470 health care rather than use a third party payer;
- 1471 (C) imposing fines, penalties, and taxes on an employer that does not meet federal
- 1472 standards for providing health care benefits for employees; and
- 1473 (D) threatening private health care systems with competing government supported
- 1474 health care systems.
- 1475 (2) (a) For purposes of this section:
- 1476 (i) "Implementation" includes adopting or changing an administrative rule; applying for
- 1477 or spending federal grant money; issuing a request for proposal to carry out a requirement of
- 1478 PPACA, entering into a memorandum of understanding with the federal government regarding
- 1479 a provision of PPACA, or amending the state Medicaid plan.
- 1480 (ii) "PPACA" is as defined in Section 31A-1-301.
- 1481 [~~(2)(a)~~] (b) A department or agency of the state may not implement any part of [federal
- 1482 ~~health care reform, as defined in Subsection (3), that is passed by the United States Congress~~

1483 after March 1, 2010,] PPACA unless, prior to implementation, the department or agency
1484 reports in writing, and ~~H→~~ **, if practicable,** ~~←H~~ in person if requested, to the Legislature's Business
1484a and Labor Interim
1485 Committee [~~and if authorized~~], the Health Reform Task Force, ~~H→~~ **[and] or** ~~←H~~ the legislative
1485a Executive
1486 Appropriations Committee in accordance with Subsection (2)~~(c)~~(d).
1487 ~~(b)~~ (c) The Legislature may pass legislation specifically authorizing or prohibiting the
1488 state's compliance with, or participation in~~[- federal health care reform]~~ provisions of PPACA.
1489 ~~(c)~~ (d) The report required under Subsection (2)~~(a)~~(b) shall include:
1490 (i) the specific federal statute or regulation that requires the state to implement a
1491 ~~[federal reform]~~ provision of PPACA;
1492 (ii) whether ~~[the reform provision]~~ PPACA has any state waiver or options;
1493 (iii) exactly what ~~[the reform provision]~~ PPACA requires the state to do, and how it
1494 would be implemented;
1495 (iv) who in the state will be impacted by adopting the federal reform provision, or not
1496 adopting the federal reform provision;
1497 (v) what is the cost to the state or citizens of the state to implement the federal reform
1498 provision; ~~[and]~~
1499 (vi) the consequences to the state if the state does not comply with ~~[the federal reform~~
1500 provision:] PPACA;
1501 ~~[(3) For purposes of this section, "federal health care reform" means federal legislation~~
1502 or federal regulation that:]
1503 ~~[(a) mandates an individual to purchase health insurance;]~~
1504 ~~[(b) mandates a small employer to provide health insurance coverage for employees;]~~
1505 ~~[(c) imposes penalties on small employers who do not provide health insurance for~~
1506 their employees;]
1507 ~~[(d) expands the eligibility for the Medicaid program or the Children's Health~~
1508 Insurance Program, and passes the cost of that expansion to the state;]
1509 ~~[(e) creates new insurance coverage mandates; or]~~
1510 ~~[(f) creates a new government run, public insurance program.]~~
1511 (vii) the impact, if any, of the PPACA requirements regarding:
1512 (A) the state's protection of a health care provider's refusal to perform an abortion on

1513 religious or moral grounds as provided in Section 76-7-306; and

1514 (B) abortion insurance coverage restrictions provided in Section 31A-22-726.

1515 [~~(4)~~] (3) (a) [~~An individual in this state may not be required~~] The state shall not require
1516 an individual in the state to obtain or maintain health insurance as defined in [~~Section~~
1517 ~~31A-1-301~~] PPACA, regardless of whether the individual has or is eligible for health insurance
1518 coverage under any policy or program provided by or through the individual's employer or a
1519 plan sponsored by the state or federal government.

1520 (b) The provisions of this title may not be used to facilitate the federal PPACA
1521 individual mandate or to hold an individual in this state liable for any penalty, assessment, fee,
1522 or fine as a result of the individual's failure to procure or obtain health insurance coverage.

1523 (c) This section does not apply to an individual who voluntarily applies for coverage
1524 under a state administered program pursuant to Title XIX or Title XXI of the Social Security
1525 Act.

1526 Section 41. **Health Reform Task Force -- Creation -- Membership -- Interim rules**
1527 **followed -- Compensation -- Staff.**

1528 (1) There is created the Health Reform Task Force consisting of the following 11
1529 members:

1530 (a) four members of the Senate appointed by the president of the Senate, no more than
1531 three of whom may be from the same political party; and

1532 (b) seven members of the House of Representatives appointed by the speaker of the
1533 House of Representatives, no more than five of whom may be from the same political party.

1534 (2) (a) The president of the Senate shall designate a member of the Senate appointed
1535 under Subsection (1)(a) as a cochair of the task force.

1536 (b) The speaker of the House of Representatives shall designate a member of the House
1537 of Representatives appointed under Subsection (1)(b) as a cochair of the task force.

1538 (3) In conducting its business, the task force shall comply with the rules of legislative
1539 interim committees.

1540 (4) Salaries and expenses of the members of the task force shall be paid in accordance
1541 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
1542 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
1543 Sessions.

1544 (5) The Office of Legislative Research and General Counsel shall provide staff support

1545 to the task force.

1546 Section 42. **Duties -- Interim report.**

1547 (1) The task force shall review and make recommendations on the following issues:

1548 (a) the impact of implementation of the federal health reform law and federal

1549 regulations on the state;

1550 (b) options for the state regarding Medicaid expansion and reform;

1551 (c) health care cost containment strategies;

1552 (d) the role of the state defined contribution arrangement market and online health

1553 insurance market places established under PPACA;

1554 (e) governing structure for the state's defined contribution arrangement market;

1555 (f) Medicaid behavioral health delivery and payment reform models within Medicaid
1556 accountable care organizations and other county provided delivery settings, including:

1557 (i) the development of a system to encourage, track, evaluate, share, and disseminate
1558 results from existing pilot projects; and

1559 (ii) payment reform models that promote performance based reimbursement;

1560 (g) the delivery of charity care in the state, including:

1561 (i) the identification of:

1562 (A) medically underserved and needy populations and geographic areas of the state;

1563 (B) barriers in the current health care delivery and payment models to the promotion of
1564 a comprehensive charity care system; and

1565 (C) current resources available for medical care for medically under-served populations
1566 and medically underserved geographic areas in the state; and

1567 (ii) proposals to establish:

1568 (A) wellness education;

1569 (B) personal responsibility for health care; and

1570 (C) a coordinated, statewide, private sector approach to universal, basic health care for
1571 Utah's medically underserved populations and geographic areas, using private partners to affect
1572 cost savings and market efficiencies; and

1573 (h) the use of self-insured health plans by small employers and the regulation of small
1574 employer stop-loss insurance in the state.

1575 (2) A final report, including any proposed legislation, shall be presented to the

1576 Business and Labor Interim Committee before November 30, 2013, and before November 30,
 1577 2014.

1578 Section 43. **Appropriation.**

1579 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for
 1580 the fiscal year beginning July 1, 2013, and ending June 30, 2014, the following sums of money
 1581 are appropriated from resources not otherwise appropriated, or reduced from amounts
 1582 previously appropriated, out of the funds or accounts indicated. These sums of money are in
 1583 addition to any amounts previously appropriated for fiscal year 2014.

1584 To Legislature - Senate

1585 From General Fund, One-time \$30,000

1586 Schedule of Programs:

1587 Administration \$30,000

1588 To Legislature - House of Representatives \$52,000

1589 From General Fund, One-time

1590 Schedule of Programs:

1591 Administration \$52,000

1592 Section 44. **Effective date.**

1593 (1) Except as provided in Subsection (2), if approved by two-thirds of all the members
 1594 elected to each house, this bill takes effect upon approval by the governor, or the day following
 1595 the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's
 1596 signature, or in the case of a veto, the date of veto override.

1597 (2) The actions affecting Section 63I-2-231 (Effective 07/01/13) take effect on July 1,
 1598 2013.

1599 Section 45. **Repeal date.**

1600 The Health Reform Task Force is repealed December 30, 2015.