HB0160S01 compared with HB0160

~~{deleted text}~~ shows text that was in HB0160 but was deleted in HB0160S01.

inserted text shows text that was not in HB0160 but was inserted into HB0160S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

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: _____

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

Money Appropriated in this Bill:

This bill appropriates in fiscal year 2013-14:

- to the Legislature-Senate as a one-time appropriation:
  - from the General Fund, One-time, $30,000
- to the Legislature-House as a one-time appropriation:
  - from the General Fund, One-time, $52,000.

Other Special Clauses:

This bill provides an effective date.

This bill provides a repeal date.

Utah Code Sections Affected:

AMENDS:

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

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

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

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

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

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

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

~~{~~ ~~**31A-30-202.5**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5~~

~~**31A-30-205**, as last amended by Laws of Utah 2011, Chapter 400~~

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

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

63I-2-231 (Effective 07/01/13), as last amended by Laws of Utah 2012, Chapters 243 and 279

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

ENACTS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31A-23b-401, Utah Code Annotated 1953

31A-23b-402, Utah Code Annotated 1953

31A-23b-403, Utah Code Annotated 1953

31A-23b-404, Utah Code Annotated 1953

31A-30-117, Utah Code Annotated 1953

31A-30-202.6, Utah Code Annotated 1953

31A-43-101, Utah Code Annotated 1953

31A-43-102, Utah Code Annotated 1953

31A-43-201, Utah Code Annotated 1953

31A-43-202, Utah Code Annotated 1953

31A-43-301, Utah Code Annotated 1953

31A-43-302, Utah Code Annotated 1953

31A-43-303, Utah Code Annotated 1953

31A-43-304, Utah Code Annotated 1953

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

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

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

31A-2-212. Miscellaneous duties.

(1) Upon issuance of an order limiting, suspending, or revoking a person's authority to do business in Utah, and when the commissioner begins a proceeding against an insurer under

Chapter 27a, Insurer Receivership Act, the commissioner:

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

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

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

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

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

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

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

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

(i) an authorized insurer doing a surety business:

(A) files a petition for receivership; or

(B) is in receivership; or

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

(A) is in financial difficulty; or

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

(b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the

judges and clerks to notify and require a person that files with the court a bond on which the authorized insurer doing surety business is surety to immediately file a new bond with a new surety.

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

(b) The commissioner shall require an insurer that issues, sells, renews, or offers health insurance coverage in this state to comply with[~~:(a) the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191; and(b) subject to Section 63M-1-2505.5, and to the extent required or applicable under the provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152,~~] the provisions of PPACA and administrative rules adopted by the commissioner related to regulation of health benefit plans, including:

(i) lifetime and annual limits;

(ii) prohibition of rescissions;

(iii) coverage of preventive health services;

(iv) coverage for a child or dependent;

(v) pre-existing condition coverage for children;

(vi) insurer transparency of consumer information including plan disclosures, uniform coverage documents, and standard definitions;

(vii) premium rate reviews;

(viii) essential health benefits;

(ix) provider choice;

(x) waiting periods; [~~and~~]

(xi) appeals processes[~~-~~];

(xii) rating restrictions;

(xiii) uniform applications and notice provisions; and

(xiv) certification and regulation of qualified health plans.

(c) The commissioner shall preserve state control over:

(i) the health insurance market in the state;

(ii) qualified health plans offered in the state; and

(iii) the conduct of navigators, producers, and in-person assisters operating in the state.

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

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

A producer or agency licensed under this chapter, with a line of authority that permits the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized to sell, negotiate, or solicit qualified health plans offered on an exchange that is:

(1) operated in the state; ~~{and}~~or

(2) ~~{(a) }~~ operated in the state and certified by the United States Department of Health and Human Services as a:

(a) state-based exchange under PPACA;~~{ or}~~

(b) a federally facilitated exchange under PPACA~~{.}~~; or

(c) a partnership exchange under PPACA.

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

31A-23a-501. Licensee compensation.

(1) As used in this section:

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

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

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

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

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

(B) received from:

(I) an insurer; or

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

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

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

(B) a fee or amount collected by or paid to the producer that does not exceed an

amount established by the commissioner by administrative rule.

(c) (i) "Customer" means:

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

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

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

(A) an employee benefit plan; or

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

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

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

(e) "Pass-through costs" include:

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

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

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

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

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

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

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

(b) Noncommission compensation shall be:

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

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

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

the noncommission compensation.

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

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

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

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

(b) The disclosure required by this Subsection (3) shall:

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

(ii) clearly specify the amount or extent of the noncommission compensation and the existence and source of any other compensation; and

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

(c) The following additional noncommission compensation is authorized:

(i) compensation received by a producer of a compensated corporate surety who under procedures approved by a rule or order of the commissioner is paid by surety bond principal debtors for extra services;

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

(iii) compensation received by a consultant as a consulting fee, provided the consultant complies with the requirements of Section 31A-23a-401; or

(iv) other compensation arrangements approved by the commissioner after a finding that they do not violate Section 31A-23a-401 and are not harmful to the public.

(d) Subject to Section 31A-23a-402.5, a producer for the insured may receive compensation from an insured through an insurer, for the negotiation and sale of a health benefit plan, if there is a separate written agreement between the insured and the licensee for

the compensation. An insurer who passes through the compensation from the insured to the licensee under this Subsection (3)(d) is not providing direct or indirect compensation or commission compensation to the licensee.

(4) (a) For purposes of this Subsection (4), "producer" includes:

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) A producer may not accept or receive any compensation from an insurer or third party administrator for the initial placement of a health benefit plan, other than a hospital confinement indemnity policy, unless prior to the customer's initial purchase of the health benefit plan the producer discloses in writing to the customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer at the time of the disclosure.

(c) A producer shall:

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

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

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

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

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

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

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

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

(i) a person licensed as a producer who acts only as an intermediary between an insurer

and the customer's producer, including a managing general agent; or

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

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

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

(7) A licensee may not receive noncommission compensation from an insured or enrollee for providing a service or engaging in an act that is required to be provided or performed in order to receive commission compensation, except for the surplus lines transactions that do not receive commissions.

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

CHAPTER 23b. NAVIGATOR LICENSE ACT

Part 1. General Provisions

31A-23b-101. Title.

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

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

31A-23b-102. Definitions.

As used in this chapter:

(1) "Compensation" is as defined in:

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

(b) PPACA.

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

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

(ii) inform an individual about accident and health insurance plans or public programs offered on an exchange;

(b) solicit insurance; or

(c) submit to the exchange:

(i) personally identifiable information about an individual; and

(ii) an individual's selection of a particular accident and health insurance plan or public program offered on the exchange.

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

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

(ii) that is certified by the United States Department of Health and Human Services as either a state-based exchange or a federally facilitated exchange under PPACA.

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

(A) an online marketplace for the purchase of health insurance if the online marketplace is not a certified exchange under PPACA; or

(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small employers that is certified as a PPACA compliant SHOP exchange.

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

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

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

(4) "Navigator":

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

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

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

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

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

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

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

(6) "Public programs" means the state Medicaid program in Title 26, Chapter 18,

Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

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

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

Part 2. Licensing

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

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

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

(ii) a valid producer license under Subsection 31A-23a-106(2)(a) with a line of authority that permits the person to sell, negotiate, or solicit accident and health insurance.

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

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

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

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

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

(i) satisfies the:

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

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

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

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

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

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

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

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

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

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

(i) an administrative action taken against the person, including a denial of a new or

renewal license application:

(A) in another jurisdiction; or

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

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

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

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

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

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

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

(c) The report required by Subsection (2)(a) shall include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(a).

(3) (a) The department may:

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

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

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

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

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

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

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

(d) Information obtained by the department from the review of criminal history records

received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23b-204 for issuance or renewal of a license;

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

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or in-person assistor in the state.

(e) If the department requests the criminal background information, the department shall:

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

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

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

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

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

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

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

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

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

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

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

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

(A) is denied; or

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

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

(i) information about the applicant's identity;

(ii) the applicant's Social Security number;

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

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

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

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

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

(viii) any other information the commissioner reasonably requires.

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

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

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

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

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

(A) is denied; or

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

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

(i) information about the applicant's identity;

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

(iii) the designated responsible licensed individual;

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

(v) whether the applicant, or individual identified in Subsections (5)(b)(iii) and (iv),

has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23b-401; and

(vi) any other information the commissioner reasonably requires.

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

31A-23b-204. Character requirements.

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

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

(2) (a) if a natural person, the applicant is competent and trustworthy; or

(b) if the applicant is an agency:

(i) the partners, directors, or principal officers or persons having comparable powers are trustworthy; and

(ii) that it will transact business in a way that the acts that may only be performed by a licensed navigator are performed only by a natural person who is licensed under this chapter, or Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance Intermediaries;

(3) the applicant intends to comply with the surety bond requirements of Section 31A-23b-207;

(4) if a natural person, the applicant is at least 18 years of age; and

(5) the applicant does not have a conflict of interest as defined by regulations issued under PPACA.

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

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

(1) The commissioner may require applicants for a license to pass an examination and complete a training program as a requirement for a license.

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

(a) the duties and functions of a navigator;

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

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

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

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

(a) accident and health insurance plans;

(b) qualifications for and enrollment in public programs;

(c) qualifications for and enrollment in premium subsidies;

(d) cultural and linguistic competence;

(e) conflict of interest standards;

(f) exchange functions; and

(g) other requirements that may be adopted by the commissioner by administrative rule.

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

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

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

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

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

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

(i) accident and health insurance;

(ii) qualification for and enrollment in public programs;

(iii) qualification for and enrollment in premium subsidies;

(iv) cultural competency;

(v) conflict of interest standards; and

(vi) other exchange functions.

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

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

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

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

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

(i) classroom attendance;

(ii) home study;

(iii) watching a video recording;

(iv) experience credit; or

(v) another method approved by rule.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The navigator shall:

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

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

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

(a) enrollment in public programs; and

(b) qualification for premium and cost sharing subsidies.

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

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

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

(a) the name and address of the licensee;

(b) the date of license issuance; and

(c) any other information the commissioner considers necessary.

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

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

31A-23b-209. Agency designations.

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

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

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

(a) a new designation under Subsection (2); and

(b) a terminated designation under Subsection (2).

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

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

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

(A) a court;

(B) a government body; or

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

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

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

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

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

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

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

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

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

(i) the individual;

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

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

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

(iii) (A) the individual; and

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

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

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

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

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

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

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

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

(i) an address;

(ii) a telephone number; or

(iii) a business email address.

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

(3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can be obtained immediately from a central storage place or elsewhere by online computer

terminals located at the registered address.

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

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

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

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

(1) For purposes of this section:

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

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

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

(2) The commissioner may not require a license as a navigator of:

(a) a person who is employed by or contracts with:

(i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, to assist an individual with enrollment in a public program or an application for premium subsidy; or

(ii) the state, a political subdivision of the state, an entity of a political subdivision of the state, or a public school district to assist an individual with enrollment in a public program or an application for premium subsidy;

(b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social Security Act which assists an individual with enrollment in a public program or an application for premium subsidy;

(c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants, and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to sell, solicit, or negotiate accident and health insurance plans;

(d) an officer, director, or employee of a navigator:

(i) who does not receive compensation or commission from an insurer issuing an insurance contract, an agency administering a public program, an individual who enrolled in a

public program or insurance product, or an exchange; and

(ii) whose activities:

(A) are executive, administrative, managerial, clerical, or a combination thereof;

(B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the enrollment in a public program offered through the exchange;

(C) are in the capacity of a special agent or agency supervisor assisting an insurance producer or navigator;

(D) are limited to providing technical advice and assistance to a licensed insurance producer or navigator; or

(E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment in a public program; and

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

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

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

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

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

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

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

(~~(3)~~4) The commissioner may by rule exempt a class of persons from the license requirement of Subsection 31A-23b-201(1) if:

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

(i) special competence;

(ii) special trustworthiness; or

(iii) regulatory surveillance made possible by licensing; or

(b) other existing safeguards make regulation unnecessary.

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

Part 3. Unlawful Conduct and Limitation of Scope of Practice

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

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

(a) filing a report;

(b) making a false entry in a record; or

(c) willfully refraining from making a proper entry in a record.

(2) (a) Communication that contains false or misleading information relating to enrollment in an insurance plan or a public program, including information that is false or misleading because it is incomplete, may not be made by:

(i) a person who is or should be licensed under this title;

(ii) an employee of a person described in Subsection (2)(a)(i);

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) a person on behalf of any of the persons listed in this Subsection (2)(a).

(b) A licensee under this chapter may not:

(i) use any business name, slogan, emblem, or related device that is misleading or likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental agency, a PPACA exchange, insurer, or other licensee already in business; or

(ii) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency, public program, or insurer:

(A) is responsible for the insurance or public program enrollment assistance activities of the person;

(B) stands behind the credit of the person; or

(C) is a source of payment of any insurance obligation of or sold by the person.

(c) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that person is an insurer.

(3) A person may not engage in an unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that the method of competition, the act, or the practice:

(a) is misleading;

(b) is deceptive;

(c) is unfairly discriminatory;

(d) provides an unfair inducement; or

(e) unreasonably restrains competition.

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

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

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

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

(ii) administrative rule adopted by the department;

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

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

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

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

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

Part 4. License Denial and Discipline

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

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

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

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

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

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

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

(d) lapsed under this section; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

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

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

(a) this title; or

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

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

(i) revoke a license;

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

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

(iv) deny a license application.

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

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

(ii) violated:

(A) an insurance statute;

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

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

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

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

(v) refused:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(vi) had an officer who refused to:

(A) give information with respect to the navigator's affairs; or

(B) perform any other legal obligation as to an examination;

(vii) provided information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(viii) violated an insurance law, valid rule, or valid order of another state's insurance department;

(ix) obtained or attempted to obtain a license through misrepresentation or fraud;

(x) improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xi) intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) application for public program;

(xii) is convicted of a felony;

(xiii) admitted or is found to have committed an insurance unfair trade practice or fraud;

(xiv) in the conduct of business in this state or elsewhere:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xv) had an insurance license, navigator license, or its equivalent, denied, suspended, or revoked in another state, province, district, or territory;

(xvi) forged another's name to:

(A) an application for insurance;

(B) a document related to an insurance transaction;

(C) a document related to an application for a public program; or

(D) a document related to an application for premium subsidies;

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

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

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

(xx) failed to:

(A) pay state income tax; or

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

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

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

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

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

(i) the individual;

(ii) the agency, if the agency:

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

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

(iii) (A) the individual; and

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

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

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) surrendered in lieu of administrative action;

(iv) lapsed; or

(v) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

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

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

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

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

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

(7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

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

former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval of the commissioner.

(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this chapter if so ordered by a court.

(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

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

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

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

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

(b) at the issuance of a new license:

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

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

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

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

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

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

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

(3) The probation order shall state the conditions for revocation or retention of the

license, which shall be reasonable.

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

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

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

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

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

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

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

(iv) submit additional documentation required to complete the licensing process; or

(v) maintain an active license in a resident state if the licensee is a nonresident licensee.

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

(A) military service;

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

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

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

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

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

(I) an examination requirement;

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

(III) continuing education requirements; or

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

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

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

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

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

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

31A-23b-404. Penalties.

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

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

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

(ii) seek other appropriate relief.

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

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

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

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers; or

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

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

31A-30-107.5.

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

(a) whether the contract is issued to:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

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

(3) This chapter does not apply to:

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

(b) federally funded or partially funded programs.

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

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

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

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

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

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

(5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust,

may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.

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

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

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

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

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

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

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

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

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer; [~~and~~]

(d) an insurance consultant; and

(e) a navigator.

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

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

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

business [~~unless~~]:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) [~~(a)~~] A carrier that elects to discontinue offering [~~a~~] all individual health benefit [~~plan~~] plans under Subsection [~~31A-30-107(3)(c) or~~] 31A-30-107.1(3)(e) is prohibited from writing new business[~~:(i) in the small employer and~~] in the individual market in this state[~~; and (ii)~~] for a period of five years beginning on the date of discontinuation of the last individual health benefit plan coverage that is discontinued.

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

[~~(i) to promote competition; or~~]

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

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

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

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

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

(iii) may elect to discontinue all of the covered carrier's health benefit plans in the

individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e).

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

(i) is prohibited from writing new business:

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

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

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

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

(c) The prohibition described in Subsection [~~(2)~~] (3)(b)(i) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

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

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

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

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

31A-30-112. Employee participation levels.

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

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

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

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

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

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

(1) (a) The department shall conduct an actuarial review of rates submitted by [~~small employer carriers~~] a carrier that offers a small employer plan and a carrier that offers an individual plan under this chapter:

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

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

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

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

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

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

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

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

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

(c) The department shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) The statewide open enrollment period:

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

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

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

(a) shall open enrollment:

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

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

(b) may open enrollment at any time.

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

(b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c) directly to the qualified health plan issuer on behalf of an individual who receives an advance premium tax credit under PPACA.

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

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

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

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

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

Section 28. Section **31A-30-202.~~{5}~~6** is ~~{amended}~~enacted to read:

31A-30-202.~~{5}~~6.~~{ Dental}~~ Dental and vision plans on the defined contribution arrangement market.

~~{ [(1) A small employer carrier who chooses to participate in the defined contribution arrangement market:]~~

~~[(a) shall offer the defined contribution arrangement health benefit plans required by~~

~~Section 31A-30-205;]~~

~~[(b) may:]~~

~~[(i) offer additional defined contribution arrangement health benefit plans in the Health Insurance Exchange as permitted by Section 31A-30-205;]~~

~~[(ii) offer a defined benefit plan in the Health Insurance Exchange if the small employer carrier offers a defined contribution arrangement health benefit plan that is actuarially equivalent to the defined benefit plan that is offered in the Health Insurance Exchange; and]~~

~~[(iii) continue to offer defined benefit plans outside of the Health Insurance Exchange and the defined contribution arrangement market, if, except as provided in Subsection 31A-30-207(2), the carrier uses the same rating and underwriting practices in both the defined contribution arrangement market in the Health Insurance Exchange and the defined benefit market outside the Health Insurance Exchange.]~~

~~[(2) A carrier that does not elect to participate in the defined contribution arrangement market by January 1, 2011, may not participate in the defined contribution arrangement market in the Health Insurance Exchange until January 1, 2013.]~~

~~}~~ (1) Beginning ~~{July}~~January 1, ~~{2013}~~2014, a carrier may offer dental and vision plans in the defined contribution arrangement market.

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

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

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

(b) A small employer who meets the requirements of Subsection (3)(a) may elect to offer its employees:

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

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

(iii) both a vision plan and a dental plan offered in the defined contribution arrangement market.

(4) An employee whose employer has offered ~~{a dental or vision plan}~~its employees a defined contribution medical plan and met participation requirements under Subsection (3)(~~{b}~~a) may elect to enroll, or not enroll, in the dental and vision plan selected by the employer.

(5) An employer's small group must meet participation requirements established by the commissioner by administrative rule for each dental or vision plan selected by an employer under Subsection (3).

Section 29. Section ~~{**31A-30-205**}~~**31A-30-208** is amended to read:

~~{ **31A-30-205. Continuation of coverage in the defined contribution market.**~~

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

~~[(a) one health benefit plan that:]~~

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

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

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

~~[(b) one health benefit plan that:]~~

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

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

~~[(c) one health benefit plan that:]~~

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

~~[(ii) has a deductible that is within $1,000 of the highest deductible that qualifies as a federally qualified high deductible health plan, as adjusted by federal law; and]~~

~~[(iii) has an out-of-pocket maximum that qualifies as a federally qualified high~~

~~deductible health plan;]~~

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

~~[(i) include:]~~

~~[(A) the provider panel;]~~

~~[(B) the deductible;]~~

~~[(C) co-payments;]~~

~~[(D) co-insurance; and]~~

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

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

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

~~[(e) alternative coverage required by Section 31A-22-724.]~~

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

~~[(b) An insurer who offers the health benefit plans required by Subsection (1) may also offer any other health benefit plan as a defined contribution arrangement if the health benefit plan provides benefits with an aggregate actuarial value that is no lower than the actuarial value of the plan required in Subsection (1)(c).]~~

~~[(3)]~~ ~~An employee~~ in the defined contribution arrangement market ~~who has the right to extend employer coverage under Subsection 31A-22-722(1) or federal COBRA, may[: (a)] continue coverage under the employee's current plan under state mini-COBRA or federal COBRA[; or].~~

~~[(b) enroll in alternative coverage under Section 31A-22-724.]~~

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

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

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

(a) shall allow an employer to enroll in a small employer defined contribution arrangement plan; and

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

~~group selecting a defined contribution arrangement health benefit plan on or before January 1, 2012; and~~]

[~~(c)~~] (b) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) (a) [~~Except as provided in Subsection 31A-30-202.5(2), in accordance with Subsection (2)(b), on January 1 of each year, an~~] An insurer may enter or exit the defined contribution arrangement market on January 1 of each year.

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

(i) on January 1 of each year;

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

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

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

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

Section ~~{31}~~30. Section **31A-43-101** is enacted to read:

CHAPTER 43. SMALL EMPLOYER STOP-LOSS INSURANCE ACT

Part 1. General Provisions

31A-43-101. Title.

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

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

31A-43-102. Definitions.

For purposes of this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer is in compliance with the provisions of this chapter, based upon the individual's examination and including a review of the appropriate records and the actuarial assumptions and methods

used by the stop-loss insurer in establishing attachment points and other applicable determinations in conjunction with the provision of stop-loss insurance coverage.

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

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

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

(5) "Lasering":

(a) means increasing or removing stop-loss coverage for a specific individual within an employer group; and

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

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

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

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

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

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

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

Part 2. Scope of Chapter

31A-43-201. Scope of chapter.

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

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

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

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

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

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

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

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

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

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

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

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

Part 3. Stop-loss Insurance

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

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

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

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

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

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

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

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

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

(h) pay stop-loss claims:

(i) incurred during the contract period; and

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

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

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

(a) include lasering; and

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

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

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

(1) A stop-loss insurer shall demonstrate to the commissioner that the specific and aggregate attachment points retained by a small employer group under the insurer's stop-loss plan are actuarially sound.

(2) A stop-loss insurer shall file the stop-loss insurance contract form and rates with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss insurance contract may be issued or delivered in the state.

(3) A stop-loss insurer shall file with the commissioner, annually on or before April 1, in a form and manner required by the commissioner by administrative rule adopted by the commissioner:

(a) an actuarial memorandum and certification which demonstrates that the insurer is in compliance with this chapter; and

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

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

(a) a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate the rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles; and

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

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

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

A stop-loss insurance contract delivered, issued for delivery, or entered into shall include the disclosure exhibit required by the commission through administrative rule. The disclosure shall clearly describe:

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

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

(3) the aggregate attachment point and the specific attachment point; and

(4) any limitations on coverage.

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

31A-43-304. Administrative rules.

The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(1) implement this chapter;

(2) assure that differences in rates charged are reasonable and reflect objective differences in plan design;

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

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

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

(6) assure the levels of specific attachment points and aggregate attachment points retained by the small employer plans are actuarially sound and are not against the public interest; and

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

claims if a small employer plan terminates.

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

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

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

Section ~~{32}~~39. Section **63I-2-231 (Effective 07/01/13)** is amended to read:

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

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

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

Section ~~{33}~~40. Section **63M-1-2505.5** is amended to read:

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

(1) The Legislature finds that:

(a) the state has embarked on a rigorous process of implementing a strategic plan for health system reform pursuant to Section 63M-1-2505;

(b) the health system reform efforts for the state were developed to address the unique circumstances within Utah and to provide solutions that work for Utah;

(c) Utah is a leader in the nation for health system reform which includes:

(i) developing and using health data to control costs and quality; and

(ii) creating a defined contribution insurance market to increase options for employers and employees; and

(d) the federal government proposals for health system reform:

(i) infringe on state powers;

(ii) impose a uniform solution to a problem that requires different responses in different states;

(iii) threaten the progress Utah has made towards health system reform; and

(iv) infringe on the rights of citizens of this state to provide for their own health care by:

(A) requiring a person to enroll in a third party payment system;

(B) imposing fines, penalties, and taxes on a person who chooses to pay directly for

health care rather than use a third party payer;

(C) imposing fines, penalties, and taxes on an employer that does not meet federal standards for providing health care benefits for employees; and

(D) threatening private health care systems with competing government supported health care systems.

(2) (a) For purposes of this section:

(i) "Implementation" includes adopting or changing an administrative rule; applying for or spending federal grant money; issuing a request for proposal to carry out a requirement of PPACA, entering into a memorandum of understanding with the federal government regarding a provision of PPACA, or amending the state Medicaid plan.

(ii) "PPACA" is as defined in Section 31A-1-301.

[~~(2) (a)~~] (b) A department or agency of the state may not implement any part of [~~federal health care reform, as defined in Subsection (3), that is passed by the United States Congress after March 1, 2010,~~] PPACA unless, prior to implementation, the department or agency reports in writing, and in person if requested, to the Legislature's Business and Labor Interim Committee [~~and if authorized~~], the Health Reform Task Force, and the legislative Executive Appropriations Committee in accordance with Subsection (2)[~~(c)~~](d).

[~~(b)~~] (c) The Legislature may pass legislation specifically authorizing or prohibiting the state's compliance with, or participation in[~~, federal health care reform~~] provisions of PPACA.

[~~(c)~~] (d) The report required under Subsection (2)[~~(a)~~](b) shall include:

(i) the specific federal statute or regulation that requires the state to implement a [~~federal reform~~] provision of PPACA;

(ii) whether [~~the reform provision~~] PPACA has any state waiver or options;

(iii) exactly what [~~the reform provision~~] PPACA requires the state to do, and how it would be implemented;

(iv) who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision;

(v) what is the cost to the state or citizens of the state to implement the federal reform provision; [~~and~~]

(vi) the consequences to the state if the state does not comply with [~~the federal reform provision.~~] PPACA;~~(.)~~

[~~(3) For purposes of this section, "federal health care reform" means federal legislation or federal regulation that:~~]

[~~(a) mandates an individual to purchase health insurance;~~]

[~~(b) mandates a small employer to provide health insurance coverage for employees;~~]

[~~(c) imposes penalties on small employers who do not provide health insurance for their employees;~~]

[~~(d) expands the eligibility for the Medicaid program or the Children's Health Insurance Program, and passes the cost of that expansion to the state;~~]

[~~(e) creates new insurance coverage mandates; or~~]

[~~(f) creates a new government run, public insurance program.~~]

(vii) the impact, if any, of the PPACA requirements regarding:

(A) the state's protection of a health care provider's refusal to perform an abortion on religious or moral grounds as provided in Section 76-7-306; and

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

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

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

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

Section ~~{34}~~41. **Health Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

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

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

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

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

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

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

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

(5) The Office of Legislative Research and General Counsel shall provide staff support to the task force.

Section ~~{35}~~42. **Duties -- Interim report.**

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

(a) the impact of implementation of the federal health reform law and federal regulations on the state;

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

(c) health care cost containment strategies;

(d) the role of the state defined contribution arrangement market and online health insurance market places established under PPACA;

(e) governing structure for the state's defined contribution arrangement market;~~{ and}~~

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

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

(ii) payment reform models that promote performance based reimbursement~~{.~~

~~}~~;

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

(i) the identification of:

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

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

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

(ii) proposals to establish:

(A) wellness education;

(B) personal responsibility for health care; and

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

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

(2) A final report, including any proposed legislation, shall be presented to the Business and Labor Interim Committee before November 30, 2013, and before November 30, 2014.

Section ~~{36}~~43. **Appropriation.**

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

To Legislature - Senate

From General Fund, One-time		$30,000
Schedule of Programs:		
Administration	$30,000	

To Legislature - House of Representatives $52,000

From General Fund, One-time		
Schedule of Programs:		
Administration	$52,000	

Section ~~{37}~~44. **Effective date.**

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

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

Section ~~{38}~~45. **Repeal date.**

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

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~~**Legislative Review Note**~~

~~**as of 2-20-13 7:06 PM**~~

~~**Office of Legislative Research and General Counsel}**~~