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H.B. 141
1st Sub. (Buff)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH REFORM AMENDMENTS

2014 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

- amends the period of time in which an employee of a state contractor must be enrolled in health insurance to conform to federal law;
- updates language regarding the prohibition against Medicaid expansion to reflect current federal regulations;
- creates a two year pilot program known as Access Utah to provide a defined contribution health benefit to individuals who are below the federal poverty level and meet other need based requirements;
- establishes a coordinated care model for providing care in Access Utah;
- instructs the Department of Health to:
  - work with the Legislature's Health Reform Task Force to develop a Section 1332 Medicaid waiver; and
  - submit an amendment of the Utah Premium Partnership and Primary Care Network waiver to the Centers for Medicare and Medicaid Services to

incorporate the Access Utah program.

- amends the Utah Health Data Authority Act to facilitate:
  - the coordination of eligibility for health insurance benefits; and
  - cost and quality reports for episodes of care;
- amends the health insurance navigator license chapter of the Insurance Code to:
  - create two types of navigator licenses;
  - establish different training for the types of licenses; and
  - add an exception to the license requirement for Indian health centers;
- amends the state Comprehensive Health Insurance Pool to:
  - close the pool to new enrollees;
  - pay out claims incurred by enrollees; and
  - close down the business of the pool;

Ĥ→ ▸ **permits an enrollee to re-new an insurance plan as long as permitted by federal policy;** ←Ĥ

- establishes the state option for calculating the cost to the state if the state mandates additional benefits to the PPACA essential health benefits;
- creates the Individual and Small Employer Risk Adjustment Act, which:
  - requires the insurance commissioner to work with stakeholders to develop a state based risk adjustment program for the individual and small group market;
  - describes the risk adjustment models the commissioner may consider;
  - requires the commissioner to report to the Legislature before implementing a risk adjustment model;
  - authorizes the commissioner to set fees for the operation of the risk adjustment program; and
  - establishes an Individual and Small Employer Risk Adjustment Enterprise Fund for the operation of the program;
- requires the Office of Consumer Health Services, which runs the small employer health insurance exchange, to provide the form required for the federal small employer premium tax credit to small employers who purchase qualified health plans; and
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides an effective date.

This bill coordinates with H.B. 24, Insurance Related Amendments, by providing superseding and substantive amendments.

This bill coordinates with H.B. 35, Reauthorization of Utah Health Data Authority Act, by providing superseding and substantive amendments.

Utah Code Sections Affected:

AMENDS:

17B-2a-818.5, as last amended by Laws of Utah 2012, Chapter 347

19-1-206, as last amended by Laws of Utah 2012, Chapter 347

26-18-18, as enacted by Laws of Utah 2013, Chapter 477

26-33a-106.1, as last amended by Laws of Utah 2012, Chapter 279

26-33a-106.5, as last amended by Laws of Utah 2012, Chapter 279

26-33a-109, as last amended by Laws of Utah 2010, Chapter 68

31A-4-115, as last amended by Laws of Utah 2002, Chapter 308

31A-8-402.3, as last amended by Laws of Utah 2004, Chapter 329

31A-22-721, as last amended by Laws of Utah 2011, Chapter 284

31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-211, as enacted by Laws of Utah 2013, Chapter 341

31A-29-106, as last amended by Laws of Utah 2013, Chapter 319

31A-29-110, as last amended by Laws of Utah 2012, Chapter 347

31A-29-111, as last amended by Laws of Utah 2012, Chapters 158 and 347

31A-29-113, as last amended by Laws of Utah 2013, Chapter 319

31A-29-114, as last amended by Laws of Utah 2006, Chapter 95

31A-29-115, as last amended by Laws of Utah 2004, Chapter 2

31A-30-103, as last amended by Laws of Utah 2013, Chapter 168

31A-30-107, as last amended by Laws of Utah 2009, Chapter 12

31A-30-108, as last amended by Laws of Utah 2011, Chapter 284

31A-30-117, as enacted by Laws of Utah 2013, Chapter 341

63A-5-205, as last amended by Laws of Utah 2012, Chapter 347

63C-9-403, as last amended by Laws of Utah 2012, Chapter 347

63I-1-231 **(Effective 07/01/14)**, as last amended by Laws of Utah 2013, Chapters 261 and 417

63M-1-2504, as last amended by Laws of Utah 2013, Chapter 255

72-6-107.5, as last amended by Laws of Utah 2012, Chapter 347

79-2-404, as last amended by Laws of Utah 2012, Chapter 347

ENACTS:

26-18-20, Utah Code Annotated 1953

31A-23b-202.5, Utah Code Annotated 1953

31A-30-118, Utah Code Annotated 1953

31A-30-301, Utah Code Annotated 1953

31A-30-302, Utah Code Annotated 1953

31A-30-303, Utah Code Annotated 1953

Utah Code Sections Affected by Coordination Clause:

26-33a-106.1, as last amended by Laws of Utah 2012, Chapter 279

31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341

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

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

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

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

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

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

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

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

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

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

the duration of the contract is subject to penalties in accordance with an ordinance adopted by the public transit district under Subsection (6).

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

(6) The public transit district shall adopt ordinances:

(a) in coordination with:

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

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

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

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

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

(b) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

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

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

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

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

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

(I) actuary; or

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

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

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

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

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

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

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

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

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

(b) the contract or agreement is between:

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

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

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

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

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

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

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

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

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

Section 3. Section **26-18-18** is amended to read:

26-18-18. Optional Medicaid expansion.

(1) For purposes of this section:

(a) "Optional expansion population" means individuals who:

(i) do not qualify for the state's Medicaid program; and

(ii) the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services would otherwise determine are eligible for funding at the enhanced federal medical assistance percentage available under PPACA beginning January 1, 2014.

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

(2) The department and the governor shall not expand the state's Medicaid program to the optional expansion population under PPACA unless:

[~~(a) the Health Reform Task Force has completed a thorough analysis of a statewide charity care system;~~]

[~~(b) the department and its contractors have:~~]

[~~(i) completed a thorough analysis of the impact to the state of expanding the state's Medicaid program to optional populations under PPACA; and~~]

[~~(ii) made the analysis conducted under Subsection (2)(b)(i) available to the public;~~]

[~~(c)~~] (a) the governor or the governor's designee has reported the intention to expand the state Medicaid program under PPACA to the Legislature in compliance with the legislative review process in Sections 63M-1-2505.5 and 26-18-3; and

[~~(d)~~] (b) notwithstanding Subsection 63J-5-103(2), the governor submits the request for expansion of the Medicaid program for optional populations to the Legislature under the high impact federal funds request process required by Section 63J-5-204, Legislative review and approval of certain federal funds request.

Section 4. Section **26-18-20** is enacted to read:

26-18-20. Access Utah -- Eligibility -- Defined contribution.

(1) For purposes of this section:

(a) "Access Utah" means the defined contribution program created in this section.

(b) "Medically frail" means an individual who meets the criteria of 42 C.F.R. 440.315 as determined by the department based on methodology administered by the department or another entity selected by the department.

(c) "Optional expansion population" is as defined in Section 26-18-18.

(2) (a) The department shall establish a two-year pilot program known as "Access Utah" which shall:

(i) begin on January 1, 2015, and end on January 1, 2017; and

(ii) provide a defined contribution to eligible individuals in accordance with this section.

(b) The department shall work with the Legislature's Health Reform Task Force to develop a Medicaid waiver proposal under Section 1332 of the Social Security Act to submit to the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(3) An individual is eligible for Access Utah if the individual:

(a) (i) is in the optional expansion population and below 100% of the federal poverty level; and

(ii) (A) is medically frail; or

(B) is an adult with a child; and

(b) if funding permits, is an individual described in Subsection (3)(a)(i), but not Subsection (3)(a)(ii).

(4) (a) Within appropriations from the Legislature, the department shall offer to an eligible individual a defined contribution in an amount determined by the department.

(b) An eligible individual shall use the defined contribution to purchase employer sponsored health insurance coverage if the individual is offered employer sponsored coverage.

(c) If an eligible individual is not offered employer sponsored health insurance coverage, the individual may use the defined contribution to purchase:

(i) a commercial health insurance policy; or

(ii) access to a coordinated care model described in Subsection (5).

(5) (a) The department may contract with public and private entities to provide or manage the delivery of a coordinated care model to an individual described in Subsection (4)(c)(ii).

(b) The coordinated care model shall combine state and federal funding with charity care resources to:

(i) provide, as funding permits, preventive care, outpatient care, pharmacy benefits, urgent and emergency care, and limited hospital benefits; and

(ii) integrate physical health and behavioral health services.

(6) The department shall evaluate and report to the Legislature's Health Reform Task

Force on or before November 1, 2016, regarding:

(a) the methods used to determine a medically frail individual, and the number of medically frail individuals who enrolled in Access Utah;

(b) access to and quality of care in Access Utah; and

(c) whether Access Utah helped to facilitate enrollee self-sufficiency.

(7) (a) Notwithstanding Section 26-18-18, the department shall seek an extension of Utah's Primary Care Network and the Utah Premium Partnership 1115 Waiver from the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services in accordance with Subsection (7)(b).

(b) The department may modify the Primary Care Network and the Utah Premium Partnership scope of benefits and eligibility criteria as part of the waiver request under Subsection (7)(a) if:

(i) the department develops the waiver request in coordination with the Legislature's Health Reform Task Force and reports to the Legislature's Executive Appropriations Committee regarding the waiver request; and

(ii) the modification of benefits will:

(A) not increase the state's expenditure for the Access Utah program beyond the Legislature's appropriation for the program; and

(B) further the state's goal to reduce health costs, improve access to care, and improve health outcomes of Utah citizens.

Section 5. Section **26-33a-106.1** is amended to read:

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

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

[~~(b) The advisory panel shall include:~~]

[~~(i) the chairman of the Utah Hospital Association;~~]

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

[~~(iii) a representative of the Utah Medical Association;~~]

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

~~Association;~~]

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

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

[~~(vii) a representative from the committee;~~]

[~~(viii) a consumer advocate appointed by the committee;~~]

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

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

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

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

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

[~~(ii)~~] (b) share data regarding insurance claims and an individual's and small employer group's health risk factor and characteristics of insurance arrangements that affect claims and usage with [~~insurers participating in the defined contribution market created in Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements~~] the Insurance Department, only to the extent necessary for:

(i) risk adjusting; and

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

[~~(A) establishing rates and prospective risk adjusting in the defined contribution arrangement market; and~~]

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

[~~(iii)~~] (c) assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting on:

[~~(A)~~] (i) geographic variances in medical care and costs as demonstrated by data available to the committee; Ĥ→ **[~~I~~] and [~~I~~]** ←Ĥ

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

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

States Bureau of Labor Statistics;

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

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

Ĥ→ **[~~(iii)~~] (d) provide on** ←Ĥ at least a monthly basis, enrollment data collected by the committee to a not-for-profit, broad-based coalition of state health care insurers and health care providers that are involved in the standardized electronic exchange of health data as described in Section 31A-22-614.5, to the extent necessary:

(A) for the department or the Medicaid Office of the Inspector General to determine insurance enrollment of an individual for the purpose of determining Medicaid third part liability;

(B) for an insurer that is a data supplier, to determine insurance enrollment of an individual for the purpose of coordination of health care benefits; and

(C) for a health care provider, to determine insurance enrollment for a patient for the purpose of claims submission by the health care provider.

(2) (a) The Medicaid Office of Inspector General shall annually report to the Legislature's Health and Human Services Interim Committee regarding how the office used the data obtained under Subsection (1)(c)(iii) and the results of obtaining the data.

(b) A data supplier shall not be liable for a breach of or unlawful disclosure of the data obtained by an entity described in Subsection (1)(c)(iii).

[~~(b)~~] (3) The plan adopted under [~~this~~] Subsection [~~(2)~~] (1) shall include:

[~~(i)~~] (a) the type of data that will be collected;

[~~(ii)~~] (b) how the data will be evaluated;

[~~(iii)~~] (c) how the data will be used;

[~~(iv)~~] (d) the extent to which, and how the data will be protected; and

[~~(v)~~] (e) who will have access to the data.

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

26-33a-106.5. Comparative analyses.

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

(2) (a) [~~The~~] Except as provided in Subsection (7)(c), the committee shall publish

compilations or reports from the data it collects under this chapter or from any other source which:

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

(ii) compare and identify by name at least a majority of the health care facilities, health care plans, and institutions in the state.

(b) [~~The~~] Except as provided in Subsection (7)(c), the report required by this Subsection (2) shall:

(i) be published at least annually; and

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

(A) nationally or other generally recognized quality standards;

(B) charges; and

(C) nationally recognized patient safety standards.

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

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

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

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

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

(6) (a) The department shall include in the report required by Subsection (2)(b), or include in a separate report, comparative information on commonly recognized or generally agreed upon measures of cost and quality identified in accordance with Subsection (7), for:

(i) routine and preventive care; and

(ii) the treatment of diabetes, heart disease, and other illnesses or conditions as determined by the committee.

(b) The comparative information required by Subsection (6)(a) shall be based on data collected under Subsection (2) and clinical data that may be available to the committee, and shall [~~beginning on or after July 1, 2012,~~] compare:

(i) beginning December 31, 2014, results for health care facilities or institutions;

(ii) beginning December 31, 2014, results for health care providers by geographic regions of the state;

[~~(ii)~~] (iii) beginning July 1, 2016, a clinic's aggregate results for a physician who practices at a clinic with five or more physicians; and

[~~(iii)~~] (iv) beginning July 1, 2016, a geographic region's aggregate results for a physician who practices at a clinic with less than five physicians, unless the physician requests physician-level data to be published on a clinic level.

(c) The department:

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

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

(iii) shall identify and report to the Legislature's Health and Human Services Interim Committee by July 1, [~~2012~~] 2014, and every July 1[~~,~~] thereafter until July 1, [~~2015, at least five~~] 2019, at least three new measures of quality to be added to the report each year.

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

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

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

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

(b) If the entity described in Subsection (7)(a) does not submit the quality measures, the department may select the appropriate number of quality measures for purposes of the report required by Subsection (6).

(c) (i) For purposes of the reports published on or after July 1, [~~2012~~] 2014, the department may not compare individual facilities or clinics as described in Subsections (6)(b)(i) through [~~(iii)~~] (iv) if the department determines that the data available to the department can not be appropriately validated, does not represent nationally recognized measures, does not reflect the mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing providers.

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

Section 7. Section **26-33a-109** is amended to read:

26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.

(1) The committee may not disclose any identifiable health data unless:

(a) the individual has authorized the disclosure; or

(b) the disclosure complies with the provisions of:

(i) this section[~~.~~];

(ii) insurance enrollment and coordination of benefits under Subsection 26-33a-104(1)(b); or

(iii) risk adjusting under Subsection 26-33a-106.1(1)(c)(iii).

(2) The committee shall consider the following when responding to a request for disclosure of information that may include identifiable health data:

(a) whether the request comes from a person after that person has received approval to do the specific research and statistical work from an institutional review board; and

(b) whether the requesting entity complies with the provisions of Subsection (3).

(3) A request for disclosure of information that may include identifiable health data shall:

(a) be for a specified period; or

(b) be solely for bona fide research and statistical purposes as determined in accordance with administrative rules adopted by the department, which shall require:

(i) the requesting entity to demonstrate to the department that the data is required for the research and statistical purposes proposed by the requesting entity; and

(ii) the requesting entity to enter into a written agreement satisfactory to the department to protect the data in accordance with this chapter or other applicable law.

(4) A person accessing identifiable health data pursuant to Subsection (3) may not further disclose the identifiable health data:

(a) without prior approval of the department; and

(b) unless the identifiable health data is disclosed or identified by control number only.

Section 8. Section **31A-4-115** is amended to read:

31A-4-115. Plan of orderly withdrawal.

(1) (a) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, the insurer shall file with the commissioner a plan of orderly withdrawal.

(b) For purposes of this section, a discontinuance of a health benefit plan pursuant to one of the following provisions is a withdrawal from a line of insurance:

(i) Subsection 31A-30-107(3)(e); or

(ii) Subsection 31A-30-107.1(3)(e).

(2) An insurer's plan of orderly withdrawal shall:

(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to its Utah policyholders and claimants;

(iii) meeting any applicable statutory obligations; and

(iv) (A) the payment of a withdrawal fee of $50,000 to the Utah Comprehensive Health Insurance Pool if:

(I) the insurer is an accident and health insurer; and

(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner; or

(B) the payment of a withdrawal fee of $50,000 to the department if:

(I) the insurer is not an accident and health insurer; and

(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner.

(3) The commissioner shall approve a plan of orderly withdrawal if the plan adequately demonstrates that the insurer will:

(a) protect the interests of the people of the state;

(b) meet the insurer's contractual obligations;

(c) provide service to the insurer's Utah policyholders and claimants; and

(d) meet any applicable statutory obligations.

(4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

(5) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that:

(a) there is reasonable cause to conclude that the interests of the people of the state are best served by such action; and

(b) the insurer:

(i) has filed a plan of orderly withdrawal; or

(ii) intends to:

(A) withdraw from writing a line of insurance in this state; or

(B) reduce the insurer's total annual premium volume by 75% or more.

(6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:

(a) withdraws from writing insurance in this state; or

(b) reduces its total annual premium volume by 75% or more in any year without having submitted a plan or receiving the commissioner's approval.

(7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years unless[~~: (a)~~] the commissioner finds that the prohibition should be waived because the waiver is:

[~~(i)~~] (a) in the public interest to promote competition; or

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

[~~(b) the insurer complies with Subsection 31A-30-108(5), if applicable.~~]

(8) The commissioner shall adopt rules necessary to implement this section.

Section 9. Section **31A-8-402.3** is amended to read:

31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed[~~: (a)~~] for a network plan, if:

[~~(i)~~] (a) there is no longer any enrollee under the group health plan who lives, resides, or works in:

[~~(A)~~] (i) the service area of the insurer; or

[~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or

[~~(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection~~ 31A-30-108~~(7); or~~]

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:

(I) all other health benefit products currently being offered by the insurer in the market; or

(II) in the case of a large employer, any other health benefit product currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A large employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's minimum participation requirements.

(7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

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

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

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

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

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

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

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

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 10. Section **31A-22-721** is amended to read:

31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed[~~: (a)~~] for a network plan, if:

[~~(i)~~] (a) there is no longer any enrollee under the group health plan who lives, resides, or works in:

[~~(A)~~] (i) the service area of the insurer; or

[~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or

[~~(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the

coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state;

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:

(I) by the insurer in the market; or

(II) in the case of a large employer, any other health benefit plan currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, the insurer acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to a new participant or beneficiary who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans:

(A) in the small employer market; or

(B) the large employer market; or

(C) both the small and large employer markets; and

(ii) (A) provides notice of the discontinuance in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 business days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of a plan sponsor or employee;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A large employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's minimum participation requirements.

(7) (a) Except as provided in Subsection (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

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

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

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

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

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

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

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

(a) at the time of coverage renewal; and

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

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

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

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

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(12) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average less than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

(13) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.

Section 11. Section **31A-23b-202.5** is enacted to read:

31A-23b-202.5. License types.

(1) A license issued under this chapter shall be issued under the license types described in Subsection (2).

(2) A license type under this chapter shall be a navigator line of authority or a certified application counselor line of authority. A license type is intended to describe the matters to be considered under any education, examination, and training required of an applicant under this chapter.

(3) (a) A navigator line of authority includes the enrollment process as described in Subsection 31A-23b-102(4)(a).

(b) (i) A certified application counselor line of authority is limited to providing information and assistance to individuals and employees about public programs and premium subsidies available through the exchange.

(ii) A certified application counselor line of authority does not allow the certified application counselor to assist a person with the selection of or enrollment in a qualified health plan offered on an exchange.

Section 12. Section **31A-23b-205** is amended to read:

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

(1) The commissioner may require [~~applicants~~] an applicant 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) (a) For the navigator line of authority, the training required by Subsection (1) shall consist of at least 21 credit hours of training before obtaining the license, which shall include at least two hours of training on:

(i) defined contribution arrangements and the small employer health insurance exchange; and

(ii) the navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) For the certified application counselor line of authority, the training required by Subsection (1) shall consist of at least six hours of training before obtaining a license, which shall include at least one hour of training on:

(i) defined contribution arrangements and the small employer health insurance exchange; and

(ii) the certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.

[~~(5)~~] (6) This section applies only to [~~applicants who are natural persons~~] an applicant who is a natural person.

Section 13. Section **31A-23b-206** is amended 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~~] For a navigator line of authority, continuing education requirements shall require:

(i) that a licensee complete [~~24~~] 12 credit hours of continuing education for every [~~two-year~~] one-year licensing period;

(ii) that [~~3~~] at least two of the [~~24~~] 12 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.~~]

(iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and

(iv) that a licensee complete the annual navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) For a certified application counselor, the continuing education requirements shall require:

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

(ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on ethics courses;

(iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and

(iv) that a licensee complete the annual certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.

[~~(b)~~] (c) An hour of continuing education in accordance with [~~Subsection~~] Subsections (3)(a)(i) and (b)(i) may be obtained through:

(i) classroom attendance;

(ii) home study;

(iii) watching a video recording; or

[~~(iv) experience credit; or~~]

[~~(v)~~] (iv) another method approved by rule.

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

[~~(d)~~] (e) 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)~~] (i) offer a qualified program on a geographically accessible basis; and

[~~(B)~~] (ii) 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 14. Section **31A-23b-211** is amended 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[~~.~~]; and

(f) an Indian health clinic or Urban Indian Health Center, as defined in Title V of the Indian Health Care Improvement Act, which assists a person with enrollment in a public program or an application for a premium subsidy.

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

(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 15. Section **31A-29-106** is amended to read:

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall [~~have the specific authority to~~]:

(a) have the specific authority to enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

[~~(d) issue policies of insurance in accordance with the requirements of this chapter;~~]

(d) (i) close enrollment in the plans issued by the pool and cancel the plans issued by the pool in accordance with the plan of operation approved by the commissioner; and

(ii) close out the business of the pool in accordance with the plan of operation, including processing and paying valid claims incurred by enrollees prior to the date enrollment is closed under Subsection (1)(d)(i);

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool and to close pool business in accordance with Subsection (1)(d);

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual and a final audit of its operations by the state auditor;

[~~(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;~~]

[~~(i)~~] (h) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

[~~(j) offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;~~]

[~~(k)~~] (i) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

[~~(l)~~] (j) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

[~~(m)~~] (k) administer the Pool Fund;

[~~(n)~~] (l) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter;

[~~(o)~~] (m) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products; and

[~~(p)~~] (n) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage, regardless of preexisting conditions, under PPACA.

(2) (a) The board shall prepare and submit an annual and final report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

[~~(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.~~]

[~~(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.~~]

Section 16. Section **31A-29-110** is amended to read:

31A-29-110. Pool administrator -- Selection -- Powers.

(1) The board shall select a pool administrator in accordance with Title 63G, Chapter 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) ability to manage medical expenses;

(b) proven ability to handle accident and health insurance;

(c) efficiency of claim paying procedures;

(d) marketing and underwriting;

(e) proven ability for managed care and quality assurance;

(f) provider contracting and discounts;

(g) pharmacy benefit management;

(h) an estimate of total charges for administering the pool; and

(i) ability to administer the pool in a cost-efficient manner.

(2) A pool administrator may be:

(a) a health insurer;

(b) a health maintenance organization;

(c) a third-party administrator; or

(d) any person or entity which has demonstrated ability to meet the criteria in Subsection (1).

(3) [~~(a)~~] The pool administrator shall serve for a period of three years, with [~~two one-year~~] yearly extension options until the operations of the pool are closed pursuant to Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract between the board and the administrator.

[~~(b) At least one year prior to the expiration of the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator~~].

[~~(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of the period of service under Subsection (3)(a).~~]

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

(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by statute to be confidential;

(b) perform all marketing, eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;

(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from enrollees;

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

(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and

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

(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which reports shall be determined by the board;

(f) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and submit a report of this information to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and

(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Section 17. Section **31A-29-111** is amended to read:

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

(1) (a) Except as provided in Subsection (1)(b) and Subsection 31A-29-106(1)(d), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(vi) the individual's health condition does not meet the criteria established under Subsection (5);

(vii) the individual is eligible for coverage under an employer group that offers a health benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) the individual is covered under any other health benefit plan;

(ix) except as provided in Subsections (3) and (6), at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application; or

(x) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(2) (a) Except as provided in Subsection (2)(b) and Subsection 31A-29-106(1)(d), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare,

except as provided in Section 31A-29-112;

(ii) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(iii) the individual is covered under any other health benefit plan;

(iv) the individual is eligible for coverage under an employer group that offers a health benefit plan or self-insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(vi) the individual is an inmate of a public institution; or

(vii) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health care insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

(b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

(4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).

(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under [~~Subsection~~] Section 31A-30-108[~~(3)~~].

(6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose individual health care insurance coverage was involuntarily terminated, is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii) and (x).

(b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the termination date of the previous individual health care insurance coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous individual coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived to the extent to which the waiting period was satisfied under the individual health insurance plan.

Section 18. Section **31A-29-113** is amended to read:

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section

31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(c) Section 31A-21-313 applies to coverage issued under this chapter.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

[~~(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.~~]

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

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

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

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

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

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

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

[~~(8)~~] (7) (a) A pool policy may contain provisions under which coverage for a

preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

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

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

(b) If this Subsection [~~(9)~~] (8) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

[~~(10)~~] (9) Covered benefits available from the pool may not exceed a $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 19. Section **31A-29-114** is amended to read:

31A-29-114. Deductibles -- Copayments.

(1) (a) A pool policy shall impose a deductible on a per calendar year basis.

(b) At least two deductible plans shall be offered.

(c) The deductible is applied to all of the eligible medical expenses [~~as defined in Section 31A-29-113~~,] incurred by the enrollee until the deductible has been satisfied. There are no benefits payable before the deductible has been satisfied.

(d) The pool may offer separate deductibles for prescription benefits.

(2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess of the mandatory deductible.

(b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool policy.

(3) The board shall establish maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee for each of the deductible plans offered under Subsection (1)(b).

(4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments under Subsection (3), the board may establish a coinsurance requirement to be imposed on

eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

(b) The circumstances in which the coinsurance authorized by this Subsection (4) may be imposed shall be designated in the pool policy.

(c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to exceed 5% of eligible medical expenses.

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

Section 20. Section **31A-29-115** is amended to read:

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

(1) [~~(a)~~] On the date of renewal, the pool may cancel an enrollee's policy if:

[~~(i)~~] (a) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(5); and

[~~(ii)~~] (b) the pool has provided written notice to the enrollee's last-known address no less than 60 days before cancellation[~~; and~~].

[~~(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.~~]

[~~(b) The pool shall issue a certificate of insurability to an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the requirements of Subsection 31A-29-111(5) are met.~~]

(2) The pool may cancel an enrollee's policy at any time if:

(a) the pool has provided written notice to the enrollee's last-known address no less than 15 days before cancellation; and

(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;

(ii) there is nonpayment of premiums; or

(iii) the pool determines that the enrollee does not meet the eligibility requirements set forth in Section 31A-29-111, in which case:

(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;

(B) retroactive termination may not exceed three years; and

(C) the board's remedy under this Subsection (2)(b) shall be a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with Subsection 31A-29-119(3).

Section 21. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

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

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

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

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

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

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

(iii) that is organized:

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

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

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

(b) The commissioner shall consider the following with regard to determining whether

an association of employers is a bona fide employer association under Subsection (4)(a):

(i) how association members are solicited;

(ii) who participates in the association;

(iii) the process by which the association was formed;

(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;

(v) the powers, rights and privileges of employer members; and

(vi) who actually controls and directs the activities and operations of the benefit programs.

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

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

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

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

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

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

(a) an individual; or

(b) an individual with a family.

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

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

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

(20) "Premium" means money paid by covered insureds and covered individuals as a

condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

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

(b) A covered carrier may not have:

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

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

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

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

(a) is not renewable; and

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

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

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

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

[~~(25) "Uninsurable" means an individual who:~~]

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

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

[~~(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g) and (h) for which coverage the applicant is applying.~~]

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

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

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

Section 22. Section **31A-30-107** is amended to read:

31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.

(1) Except as otherwise provided in this section, a small employer health benefit plan is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if[~~: (i)~~] there is no longer any enrollee under the group health plan who lives, resides, or works in:

[~~(A)~~] (i) the service area of the covered carrier; or

[~~(B)~~] (ii) the area for which the covered carrier is authorized to do business; [~~and~~] or

[~~(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the

coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known

to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's minimum participation requirements.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

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

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

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 23. Section **31A-30-108** is amended to read:

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

(1) (a) [~~Small employer carriers shall accept residents~~] A small employer carrier shall accept a small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a) and PPACA, Sec. 2702.

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

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

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

(b) An individual carrier shall accept an individual that applies for individual coverage as set forth in PPACA, Sec. 2702.

(2) (a) [~~Small~~] A small employer [~~carriers~~] carrier shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

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

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

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

[~~(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:~~]

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

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

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

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

[~~(ii) under:~~]

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

[~~(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;~~]

[~~(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:~~]

[~~(i) the Medicare program established under Title XVIII of the Social Security Act;~~]

[~~(ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or~~]

[~~(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;~~]

[~~(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:~~]

[~~(i) Medicare supplement policy;~~]

[~~(ii) conversion option;~~]

[~~(iii) continuation or extension under COBRA; or~~]

[~~(iv) state extension;~~]

[~~(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and~~]

[~~(e) the individual is certified as ineligible for the Health Insurance Pool if:~~]

[~~(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or~~]

[~~(ii) the individual applies for coverage with any individual carrier within 45 days after:~~]

[~~(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or~~]

[~~(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.~~]

[~~(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.~~]

[~~(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:~~]

[~~(i) cancellation of coverage under Subsection 31A-29-115(1); or~~]

[~~(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool~~].

[~~(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.~~]

[~~(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.~~]

[~~(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:~~]

[~~(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and~~]

[~~(ii) the commissioner finds that the carrier's issuance of new individual policies:~~]

[~~(A) is in the best interests of the state; and~~]

[~~(B) does not provide an unfair advantage to the carrier.~~]

[~~(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in Health Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).~~]

[~~(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the department.~~]

[~~(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:~~]

[~~(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and~~]

[~~(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:~~]

[~~(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and~~]

[~~(B) applies this section uniformly to all employers without regard to:~~]

[~~(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or~~]

[~~(II) any health status-related factor relating to an employee or dependent of an employee~~].

[~~(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.~~]

[~~(ii) This Subsection (7)(b) does not:~~]

[~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~]

[~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.~~]

[~~(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.~~]

Section 24. Section **31A-30-117** is amended 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).~~]

(3) To the extent permitted by the Centers for Medicare and Medicaid Services policy, or federal regulation, the commissioner shall allow a health insurer to choose to continue coverage and individuals and small employers to choose to re-enroll in coverage in nongrandfathered health coverage that is not in compliance with market reforms required by PPACA.

Section 25. Section **31A-30-118** is enacted to read:

31A-30-118. Patient Protection and Affordable Care Act -- State insurance mandates -- Cost of additional benefits.

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

(b) The state shall quantify the cost attributable to each additional mandated benefit specified in Subsection (1)(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.

(c) The commissioner may require a proponent of a new mandated benefit under Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance with Subsection (1)(b). The commissioner may use the cost information provided under this Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

(2) If the state is required to defray the cost of additional required benefits under the provisions of 45 C.F.R. 155.170:

(a) the state shall make the required payments:

(i) in accordance with Subsection (3); and

(ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

(b) an issuer of a qualified health plan that receives a payment under the provisions of

Subsection (1) and 45 C.F.R. 155.170 shall:

(i) reduce the premium charged to the individual on whose behalf the issuer will be paid under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); or

(ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an individual on whose behalf the issuer received a payment under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); and

(c) a premium rebate made under this section is not a prohibited inducement under Section 31A-23a-402.5.

(3) A payment required under 45 C.F.R. 155.170(c) shall:

(a) unless otherwise required by PPACA, be based on a statewide average of the cost of the additional benefit for all issuers who are entitled to payment under the provisions of 45 C.F.R. 155.70; and

(b) be submitted to an issuer through a process established and administered by:

(i) the federal marketplace exchange for the state under PPACA for individual health plans; or

(ii) Avenue H small employer market exchange for qualified health plans offered on the exchange.

(4) The commissioner:

(a) may adopt rules as necessary to administer the provisions of this section and 45 C.F.R. 155.170; and

(b) may not establish or implement the process for submitting the payments to an issuer under Subsection (3)(b)(i) unless the cost of establishing and implementing the process for submitting payments is paid for by the federal exchange marketplace.

Section 26. Section **31A-30-301** is enacted to read:

Part 3. Individual and Small Employer Risk Adjustment Act

31A-30-301. Title.

This part is known as the "Individual and Small Employer Risk Adjustment Act."

Section 27. Section **31A-30-302** is enacted to read:

31A-30-302. Creation of state risk adjustment program.

(1) The commissioner shall convene a group of stakeholders and actuaries to assist the

commissioner with the evaluation or the risk adjustment options described in Subsection (2). If the commissioner determines that a state-based risk adjustment program is in the best interest of the state, the commissioner shall establish an individual and small employer market risk adjustment program in accordance with 42 U.S.C. 18063 and this section.

(2) The risk adjustment program adopted by the commissioner may include one of the following models:

(a) continue the United States Department of Health and Human Services administration of the federal model for risk adjustment for the individual and small employer market in the state;

(b) have the state administer the federal model for risk adjustment for the individual and small employer market in the state;

(c) establish and operate a state based risk adjustment program for the individual and small employer market in the state; or

(d) another risk adjustment model developed by the commissioner under Subsection (1).

(3) Before adopting one of the models described in Subsection (2), the commissioner:

(a) may enter into contracts to carry out the services needed to evaluate and establish one of the risk adjustment options described in Subsection (2); and

(b) shall, prior to October 30, 2014, comply with the reporting requirements of Section 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options described in Subsection (2).

(4) The commissioner may:

(a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that require an insurer that is subject to the state based risk adjustment program to submit data to the all payers claims database created under Section 26-33a-106.1; and

(b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act, to cover the ongoing administrative cost of running the state based risk adjustment program.

Section 28. Section **31A-30-303** is enacted to read:

31A-30-303. Enterprise fund.

(1) There is created an enterprise fund known as the Individual and Small Employer

Risk Adjustment Enterprise Fund.

(2) The following funds shall be credited to the fund:

(a) appropriations from the General Fund;

(b) fees established by the commissioner under Section 31A-30-302;

(c) risk adjustment payments received from insurers participating in the risk adjustment program; and

(d) all interest and dividends earned on the fund's assets.

(3) All money received by the fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The fund shall comply with Title 63A, Utah Administrative Services Code.

(6) The fund shall be used to implement and operate the risk adjustment program created by this part.

Section 29. Section **63A-5-205** is amended to read:

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

(1) As used in this section:

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

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

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

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

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

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

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

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

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

may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The division shall adopt administrative rules:

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

(ii) in coordination with:

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

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

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

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

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

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

(iii) which establish:

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

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

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

(Aa) the Utah Insurance Department;

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

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

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

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

(II) a six-month suspension of the contractor or subcontractor from entering into future

contracts with the state upon the second violation;

(III) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

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

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

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

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

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

(I) an actuary; or

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

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

(iii) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (3)(g).

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

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

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

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

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

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

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

Section 30. Section **63C-9-403** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

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

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

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

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

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the

employee for health care costs that would have been covered by qualified health insurance coverage.

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

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

(I) an actuary; or

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

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

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

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

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

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

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

Section 31. Section **63I-1-231 (Effective 07/01/14)** is amended to read:

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

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.

(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2023.

(3) Section 31A-22-619.6, Coordination of benefits with workers' compensation claim--Health insurer's duty to pay, is repealed on July 1, 2018.

(4) Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is repealed July 1, 2015.

Section 32. Section **63M-1-2504** is amended to read:

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

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:

(i) provides information to consumers about private and public health programs for which the consumer may qualify;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange; and

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) contract with one or more private vendors for:

(i) administration of the enrollment process on the Health Insurance Exchange, including establishing a mechanism for consumers to compare health benefit plan features on the exchange and filter the plans based on consumer preferences;

(ii) the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others; and

(iii) establishing a call center in accordance with Subsection [~~(3)~~] (4);

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars;

(d) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the Health Insurance Exchange; [~~and~~]

(e) submit, before November 1, an annual written report to the Business and Labor Interim Committee and the Health System Reform Task Force regarding the operations of the Health Insurance Exchange required by this chapter[~~.~~]; and

(f) in accordance with Subsection (3), provide a form to a small employer that certifies:

(i) that the small employer offered a qualified health plan to the small employer's employees; and

(ii) the period of time within the taxable year in which the small employer maintained the qualified health plan coverage.

(3) The form required by Subsection (2)(f) shall be provided to a small employer if:

(a) the small employer selected a qualified health plan on the small employer health exchange created by this section; or

(b) (i) the small employer selected a health plan in the small employer market that is not offered through the exchange created by this section; and

(ii) the issuer of the health plan selected by the small employer submits to the office, in a form and manner required by the office:

(A) an affidavit from a member of the American Academy of Actuaries stating that based on generally accepted actuarial principles and methodologies the issuer's health plan meets the benefit and actuarial requirements for a qualified health plan under PPACA as defined in Section 31A-1-301; and

(B) an affidavit from the issuer that includes the dates of coverage for the small employer during the taxable year.

[~~(3)~~] (4) A call center established by the office:

(a) shall provide unbiased answers to questions concerning exchange operations, and plan information, to the extent the plan information is posted on the exchange by the insurer; and

(b) may not:

(i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

(ii) receive producer compensation through the Health Insurance Exchange; and

(iii) be designated as the default producer for an employer group that enters the Health Insurance Exchange without a producer.

[~~(4)~~] (5) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, health insurance producers, or health insurance premiums charged in the exchange;

(ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

(iii) act as an appeals entity for resolving disputes between a health insurer and an insured;

(b) may establish and collect a fee for the cost of the exchange transaction in accordance with Section 63J-1-504 for:

(i) processing an application for a health benefit plan;

(ii) accepting, processing, and submitting multiple premium payment sources;

(iii) providing a mechanism for consumers to filter and compare health benefit plans in the exchange based on consumer preferences; and

(iv) funding the call center; and

(c) shall separately itemize the fee established under Subsection [~~(4)~~] (5)(b) as part of the cost displayed for the employer selecting coverage on the exchange.

Section 33. Section **72-6-107.5** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

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

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

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

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

(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or

subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

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

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

(I) an actuary; or

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

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

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

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

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

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

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

Section 34. Section **79-2-404** is amended to read:

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

(1) For purposes of this section:

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

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

(ii) meets employer eligibility waiting requirements for health care insurance which

may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of hire.

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

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

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

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

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

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

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

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

(b) the contract or agreement is between:

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

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

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

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

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

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

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

Section 35. **Effective date.**

(1) Except as provided in Subsection (2), this bill takes effect May 13, 2014.

(2) The amendments to Section 63I-1-231 (Effective 07/01/14) take effect on July 1, 2014.

Section 36. **Coordinating H.B. 141 with H.B. 24 -- Superseding technical and substantive amendments.**

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

Section 37. **Coordinating H.B. 141 with H.B. 35 -- Superseding technical and substantive amendments**.

If this H.B. 141 and H.B. 35, Reauthorization of Health Data Authority Act, both pass

and become law, it is the intent of the Legislature that the amendments to Section 26-33a-106.1 in this bill, supersede the amendments to Section 26-33a-106.1 in H.B. 35, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.