Representative James A. Dunnigan proposes the following substitute bill:

1 # HEALTH REFORM AMENDMENTS

2 2011 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

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

11 **Highlighted Provisions:**

12 This bill:

13 ▸ amends the definition of third party payor in the Utah Health Data Authority Act;
14 ▸ requires the Health Data Authority to publish comparative data about physician and
15 clinic quality by October 1, 2011;
16 ▸ amends the membership of the Health Data Authority;
17 ▸ clarifies duties between the Department of Health, the Department of Insurance, and
18 the Office of Consumer Health Services related to:
19 • convening and supervising the health delivery and payment reform
20 demonstration projects; and
21 • regulation of insurers in the Health Insurance Exchange;
22 ▸ clarifies the dental coverage for the Children's Health Insurance Program;
23 ▸ amends the definition of qualified health plan that a state contractor shall offer to
24 employees;
25 ▸ establishes state authority to regulate certain practices of health insurers;

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

57 the department's actuarial review as dedicated credits, shall lapse to the Health Insurance
58 Actuarial Review Restricted Account;
59 ▸ repeals the statewide risk adjuster mechanism that was effective January 1, 2013;
60 and
61 ▸ makes technical and conforming amendments.
62 **Money Appropriated in this Bill:**
63 None
64 **Other Special Clauses:**
65 This bill provides a repeal date for certain provisions.
66 **Utah Code Sections Affected:**
67 AMENDS:
68 **17B-2a-818.5**, as last amended by Laws of Utah 2010, Chapter 229
69 **19-1-206**, as last amended by Laws of Utah 2010, Chapters 218 and 229
70 **26-33a-102**, as last amended by Laws of Utah 1996, Chapter 232
71 **26-33a-103**, as last amended by Laws of Utah 2010, Chapter 286
72 **26-33a-106.5**, as last amended by Laws of Utah 2005, Chapter 266
73 **26-40-106**, as last amended by Laws of Utah 2007, Chapter 47
74 **31A-2-212**, as last amended by Laws of Utah 2007, Chapter 309
75 **31A-22-613.5**, as last amended by Laws of Utah 2010, Chapters 68, 149 and last
76 amended by Coordination Clause, Laws of Utah 2010, Chapter 149
77 **31A-22-614.6**, as last amended by Laws of Utah 2010, Chapter 68
78 **31A-22-635**, as last amended by Laws of Utah 2010, Chapter 68
79 **31A-22-724**, as enacted by Laws of Utah 2009, Chapter 12
80 **31A-29-103**, as last amended by Laws of Utah 2008, Chapters 3 and 385
81 **31A-30-103**, as last amended by Laws of Utah 2010, Chapter 68
82 **31A-30-104**, as last amended by Laws of Utah 2009, Chapter 12
83 **31A-30-106.1**, as enacted by Laws of Utah 2010, Chapter 68
84 **31A-30-203**, as last amended by Laws of Utah 2010, Chapter 68
85 **31A-30-205**, as last amended by Laws of Utah 2010, Chapters 68, 149 and last
86 amended by Coordination Clause, Laws of Utah 2010, Chapter 149
87 **31A-30-207**, as last amended by Laws of Utah 2010, Chapter 68

88 **31A-30-208**, as repealed and reenacted by Laws of Utah 2010, Chapter 68
89 **31A-30-209**, as enacted by Laws of Utah 2010, Chapter 68
90 **31A-42-202**, as last amended by Laws of Utah 2010, Chapter 68
91 **63A-5-205**, as last amended by Laws of Utah 2010, Chapter 229
92 **63C-9-403**, as last amended by Laws of Utah 2010, Chapter 229
93 **63I-1-231**, as last amended by Laws of Utah 2010, Chapters 68 and 319
94 **63J-1-602.2**, as enacted by Laws of Utah 2010, Chapter 265 and last amended by
95 Coordination Clause, Laws of Utah 2010, Chapter 265
96 **63M-1-2504**, as last amended by Laws of Utah 2010, Chapter 68
97 **63M-1-2506**, as last amended by Laws of Utah 2010, Chapter 68
98 **72-6-107.5**, as last amended by Laws of Utah 2010, Chapter 229
99 **79-2-404**, as last amended by Laws of Utah 2010, Chapter 229
100 ENACTS:
101 **26-1-39**, Utah Code Annotated 1953
102 **26-40-115**, Utah Code Annotated 1953
103 **31A-23a-115.5**, Utah Code Annotated 1953
104 **31A-30-115**, Utah Code Annotated 1953
105 **31A-30-211**, Utah Code Annotated 1953
106 REPEALS:
107 **31A-42a-101 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
108 **31A-42a-102 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
109 **31A-42a-201 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
110 **31A-42a-202 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
111 **31A-42a-203 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
112 **31A-42a-204 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
113 **Uncodified Material Affected:**
114 ENACTS UNCODIFIED MATERIAL
115 REPEALS UNCODIFIED MATERIAL:
116 **Laws of Utah 2010, Chapter 68, Uncodified Section 48**
117 **Laws of Utah 2010, Chapter 68, Uncodified Section 49**
118 **Laws of Utah 2010, Chapter 68, Uncodified Section 50, Subsection (3)**

119

120 *Be it enacted by the Legislature of the state of Utah:*
121 Section 1. Section **17B-2a-818.5** is amended to read:
122 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**
123 **coverage.**
124 (1) For purposes of this section:
125 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
126 34A-2-104 who:
127 (i) works at least 30 hours per calendar week; and
128 (ii) meets employer eligibility waiting requirements for health care insurance which
129 may not exceed the first day of the calendar month following 90 days from the date of hire.
130 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
131 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
132 ~~or renewed:~~] is as defined in Section 26-40-115.
133 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
134 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
135 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
136 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
137 ~~employee who reside or work in the state, in which:~~]
138 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
139 ~~dependents of the employee who reside or work in the state; and~~]
140 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):~~]
141 [~~(I) rather that the benchmark plan's deductible, and the benchmark plan's~~
142 ~~out-of-pocket maximum based on income levels:~~]
143 [~~(Aa) the deductible is $750 per individual and $2,250 per family; and~~]
144 [~~(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;~~]
145 [~~(II) dental coverage is not required; and~~]
146 [~~(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
147 ~~not apply; or~~]
148 [~~(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
149 ~~deductible that is either:~~]

150 [~~(I) the lowest deductible permitted for a federally qualified high deductible health~~
151 ~~plan; or~~]
152 [~~(II) a deductible that is higher than the lowest deductible permitted for a federally~~
153 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
154 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
155 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
156 ~~employer offered federally qualified high deductible plan;~~]
157 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
158 ~~annual deductible; and~~]
159 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
160 ~~dependents of the employee who work or reside in the state.~~]
161 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
162 (2) (a) Except as provided in Subsection (3), this section applies to a design or
163 construction contract entered into by the public transit district on or after July 1, 2009, and to a
164 prime contractor or to a subcontractor in accordance with Subsection (2)(b).
165 (b) (i) A prime contractor is subject to this section if the prime contract is in the
166 amount of $1,500,000 or greater.
167 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
168 $750,000 or greater.
169 (3) This section does not apply if:
170 (a) the application of this section jeopardizes the receipt of federal funds;
171 (b) the contract is a sole source contract; or
172 (c) the contract is an emergency procurement.
173 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]
174 63G-6-103, or a modification to a contract, when the contract does not meet the initial
175 threshold required by Subsection (2).
176 (b) A person who intentionally uses change orders or contract modifications to
177 circumvent the requirements of Subsection (2) is guilty of an infraction.
178 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit
179 district that the contractor has and will maintain an offer of qualified health insurance coverage
180 for the contractor's employees and the employee's dependents during the duration of the

181 contract.
182 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
183 shall demonstrate to the public transit district that the subcontractor has and will maintain an
184 offer of qualified health insurance coverage for the subcontractor's employees and the
185 employee's dependents during the duration of the contract.
186 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
187 the duration of the contract is subject to penalties in accordance with an ordinance adopted by
188 the public transit district under Subsection (6).
189 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
190 requirements of Subsection (5)(b).
191 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
192 the duration of the contract is subject to penalties in accordance with an ordinance adopted by
193 the public transit district under Subsection (6).
194 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
195 requirements of Subsection (5)(a).
196 (6) The public transit district shall adopt ordinances:
197 (a) in coordination with:
198 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
199 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
200 (iii) the State Building Board in accordance with Section 63A-5-205;
201 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and
202 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
203 (b) which establish:
204 (i) the requirements and procedures a contractor must follow to demonstrate to the
205 public transit district compliance with this section which shall include:
206 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
207 (b) more than twice in any 12-month period; and
208 (B) that the actuarially equivalent determination required <u>for the qualified health</u>
209 <u>insurance coverage</u> in Subsection (1) is met by the contractor if the contractor provides the
210 department or division with a written statement of actuarial equivalency from either:
211 (I) the Utah Insurance Department;

212 (II) an actuary selected by the contractor or the contractor's insurer; or
213 (III) an underwriter who is responsible for developing the employer group's premium
214 rates;
215 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
216 violates the provisions of this section, which may include:
217 (A) a three-month suspension of the contractor or subcontractor from entering into
218 future contracts with the public transit district upon the first violation;
219 (B) a six-month suspension of the contractor or subcontractor from entering into future
220 contracts with the public transit district upon the second violation;
221 (C) an action for debarment of the contractor or subcontractor in accordance with
222 Section 63G-6-804 upon the third or subsequent violation; and
223 (D) monetary penalties which may not exceed 50% of the amount necessary to
224 purchase qualified health insurance coverage for employees and dependents of employees of
225 the contractor or subcontractor who were not offered qualified health insurance coverage
226 during the duration of the contract; and
227 (iii) a website on which the district shall post the benchmark for the qualified health
228 insurance coverage identified in Subsection (1)(c)[~~(i)~~].
229 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor
230 or subcontractor who intentionally violates the provisions of this section shall be liable to the
231 employee for health care costs that would have been covered by qualified health insurance
232 coverage.
233 (ii) An employer has an affirmative defense to a cause of action under Subsection
234 (7)(a)(i) if:
235 (A) the employer relied in good faith on a written statement of actuarial equivalency
236 provided by an:
237 (I) actuary; or
238 (II) underwriter who is responsible for developing the employer group's premium rates;
239 or
240 (B) a department or division determines that compliance with this section is not
241 required under the provisions of Subsection (3) or (4).
242 (b) An employee has a private right of action only against the employee's employer to

243 enforce the provisions of this Subsection (7).
244 (8) Any penalties imposed and collected under this section shall be deposited into the
245 Medicaid Restricted Account created in Section 26-18-402.
246 (9) The failure of a contractor or subcontractor to provide qualified health insurance
247 coverage as required by this section:
248 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
249 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
250 Legal and Contractual Remedies; and
251 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
252 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
253 or construction.
254 Section 2. Section **19-1-206** is amended to read:
255 **19-1-206. Contracting powers of department -- Health insurance coverage.**
256 (1) For purposes of this section:
257 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
258 34A-2-104 who:
259 (i) works at least 30 hours per calendar week; and
260 (ii) meets employer eligibility waiting requirements for health care insurance which
261 may not exceed the first day of the calendar month following 90 days from the date of hire.
262 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
263 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
264 ~~or renewed:~~] is as defined in Section 26-40-115.
265 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
266 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
267 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
268 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
269 ~~employee who reside or work in the state, in which:~~]
270 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
271 ~~dependents of the employee who reside or work in the state; and~~]
272 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):~~]
273 [~~(I) rather that the benchmark plan's deductible, and the benchmark plan's~~

274 ~~out-of-pocket maximum based on income levels:~~]
275 [~~(Aa) the deductible is $750 per individual and $2,250 per family; and~~]
276 [~~(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;~~]
277 [~~(II) dental coverage is not required; and~~]
278 [~~(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
279 ~~not apply; or~~]
280 [~~(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
281 ~~deductible that is either:~~]
282 [~~(I) the lowest deductible permitted for a federally qualified high deductible health~~
283 ~~plan; or~~]
284 [~~(II) a deductible that is higher than the lowest deductible permitted for a federally~~
285 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
286 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
287 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
288 ~~employer offered federally qualified high deductible plan;~~]
289 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
290 ~~annual deductible; and~~]
291 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
292 ~~dependents of the employee who work or reside in the state.~~]
293 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
294 (2) (a) Except as provided in Subsection (3), this section applies to a design or
295 construction contract entered into by or delegated to the department or a division or board of
296 the department on or after July 1, 2009, and to a prime contractor or subcontractor in
297 accordance with Subsection (2)(b).
298 (b) (i) A prime contractor is subject to this section if the prime contract is in the
299 amount of $1,500,000 or greater.
300 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
301 $750,000 or greater.
302 (3) This section does not apply to contracts entered into by the department or a division
303 or board of the department if:
304 (a) the application of this section jeopardizes the receipt of federal funds;

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

336 requirements of Subsection (5)(b).
337 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
338 the duration of the contract is subject to penalties in accordance with administrative rules
339 adopted by the department under Subsection (6).
340 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
341 requirements of Subsection (5)(a).
342 (6) The department shall adopt administrative rules:
343 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
344 (b) in coordination with:
345 (i) a public transit district in accordance with Section 17B-2a-818.5;
346 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
347 (iii) the State Building Board in accordance with Section 63A-5-205;
348 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
349 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
350 (vi) the Legislature's Administrative Rules Review Committee; and
351 (c) which establish:
352 (i) the requirements and procedures a contractor must follow to demonstrate to the
353 public transit district compliance with this section [~~which~~] that shall include:
354 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
355 (b) more than twice in any 12-month period; and
356 (B) that the actuarially equivalent determination required for the qualified health
357 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
358 department or division with a written statement of actuarial equivalency from either:
359 (I) the Utah Insurance Department;
360 (II) an actuary selected by the contractor or the contractor's insurer; or
361 (III) an underwriter who is responsible for developing the employer group's premium
362 rates;
363 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
364 violates the provisions of this section, which may include:
365 (A) a three-month suspension of the contractor or subcontractor from entering into
366 future contracts with the state upon the first violation;

367 (B) a six-month suspension of the contractor or subcontractor from entering into future
368 contracts with the state upon the second violation;
369 (C) an action for debarment of the contractor or subcontractor in accordance with
370 Section 63G-6-804 upon the third or subsequent violation; and
371 (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%
372 of the amount necessary to purchase qualified health insurance coverage for an employee and
373 the dependents of an employee of the contractor or subcontractor who was not offered qualified
374 health insurance coverage during the duration of the contract; and
375 (iii) a website on which the department shall post the benchmark for the qualified
376 health insurance coverage identified in Subsection (1)(c)[(i)].
377 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
378 subcontractor who intentionally violates the provisions of this section shall be liable to the
379 employee for health care costs that would have been covered by qualified health insurance
380 coverage.
381 (ii) An employer has an affirmative defense to a cause of action under Subsection
382 (7)(a)(i) if:
383 (A) the employer relied in good faith on a written statement of actuarial equivalency
384 provided by:
385 (I) an actuary; or
386 (II) an underwriter who is responsible for developing the employer group's premium
387 rates; or
388 (B) the department determines that compliance with this section is not required under
389 the provisions of Subsection (3) or (4).
390 (b) An employee has a private right of action only against the employee's employer to
391 enforce the provisions of this Subsection (7).
392 (8) Any penalties imposed and collected under this section shall be deposited into the
393 Medicaid Restricted Account created in Section 26-18-402.
394 (9) The failure of a contractor or subcontractor to provide qualified health insurance
395 coverage as required by this section:
396 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
397 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,

398 Legal and Contractual Remedies; and
399 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
400 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
401 or construction.
402 Section 3. Section **26-1-39** is enacted to read:
403 **26-1-39. Health System Reform Demonstration Projects.**
404 The department may coordinate with the Insurance Department and periodically
405 convene health care providers, payers, and consumers, who elect to participate in a
406 demonstration project under Section 31A-22-614.6, to monitor the progress being made
407 regarding demonstration projects for health care delivery and payment reform under Section
408 31A-22-614.6.
409 Section 4. Section **26-33a-102** is amended to read:
410 **26-33a-102. Definitions.**
411 As used in this chapter:
412 (1) "Committee" means the Health Data Committee created by Section 26-1-7.
413 (2) "Control number" means a number assigned by the committee to an individual's
414 health data as an identifier so that the health data can be disclosed or used in research and
415 statistical analysis without readily identifying the individual.
416 (3) "Data supplier" means a health care facility, health care provider, self-funded
417 employer, third-party payor, health maintenance organization, or government department which
418 could reasonably be expected to provide health data under this chapter.
419 (4) "Disclosure" or "disclose" means the communication of health care data to any
420 individual or organization outside the committee, its staff, and contracting agencies.
421 (5) "Executive director" means the director of the department.
422 (6) "Health care facility" means a facility that is licensed by the department under Title
423 26, Chapter 21, Health Care Facility [~~Licensure~~] Licensing and Inspection Act. The committee
424 may by rule add, delete, or modify the list of facilities that come within this definition for
425 purposes of this chapter.
426 (7) "Health care provider" means any person, partnership, association, corporation, or
427 other facility or institution that renders or causes to be rendered health care or professional
428 services as a physician, registered nurse, licensed practical nurse, nurse-midwife, dentist, dental

429 hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, podiatric
430 physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician,
431 osteopathic physician and surgeon, audiologist, speech pathologist, certified social worker,
432 social service worker, social service aide, marriage and family counselor, or practitioner of
433 obstetrics, and others rendering similar care and services relating to or arising out of the health
434 needs of persons or groups of persons, and officers, employees, or agents of any of the above
435 acting in the course and scope of their employment.
436 (8) "Health data" means information relating to the health status of individuals, health
437 services delivered, the availability of health manpower and facilities, and the use and costs of
438 resources and services to the consumer, except vital records as defined in Section 26-2-2 shall
439 be excluded.
440 (9) "Health maintenance organization" has the meaning set forth in Section 31A-8-101.
441 (10) "Identifiable health data" means any item, collection, or grouping of health data
442 that makes the individual supplying or described in the health data identifiable.
443 (11) "Individual" means a natural person.
444 (12) "Organization" means any corporation, association, partnership, agency,
445 department, unit, or other legally constituted institution or entity, or part thereof.
446 (13) "Research and statistical analysis" means activities using health data analysis
447 including:
448 (a) describing the group characteristics of individuals or organizations;
449 (b) analyzing the noncompliance among the various characteristics of individuals or
450 organizations;
451 (c) conducting statistical procedures or studies to improve the quality of health data;
452 (d) designing sample surveys and selecting samples of individuals or organizations;
453 and
454 (e) preparing and publishing reports describing these matters.
455 (14) "Self-funded employer" means an employer who provides for the payment of
456 health care services for [~~his~~] employees directly from the employer's funds, thereby assuming
457 the financial risks rather than passing them on to an outside insurer through premium
458 payments.
459 (15) "Plan" means the plan developed and adopted by the Health Data Committee

460 under Section 26-33a-104.
461 (16) "Third party payor" means [any]:
462 (a) an insurer offering a health [care insurance] benefit plan, as defined by Section
463 31A-1-301, [any] to at least 2,500 enrollees in the state;
464 (b) a nonprofit health service insurance corporation licensed under Title 31A, Chapter
465 7, Nonprofit Health Service Insurance Corporations[, any];
466 (c) a program funded or administered by [the state of] Utah for the provision of health
467 care services, including the Medicaid and medical assistance programs described in [Title 26,]
468 Chapter 18[, or any other similar], Medical Assistance Act; and
469 (d) a corporation, organization, association, entity, or person[.]:
470 (i) which administers or offers a health benefit plan to at least 2,500 enrollees in the
471 state; and
472 (ii) which is required by administrative rule adopted by the department in accordance
473 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to supply health data to the
474 committee.
475 Section 5. Section **26-33a-103** is amended to read:
476 **26-33a-103. Committee membership -- Terms -- Chair -- Compensation.**
477 (1) The Health Data Committee created by Section 26-1-7 shall be composed of 13
478 members appointed by the governor with the consent of the Senate.
479 (2) No more than seven members of the committee may be members of the same
480 political party.
481 (3) The appointed members of the committee shall be knowledgeable regarding the
482 health care system and the characteristics and use of health data and shall be selected so that
483 the committee at all times includes individuals who provide care.
484 (4) The membership of the committee shall be:
485 (a) one person employed by or otherwise associated with a hospital as defined by
486 Section 26-21-2, who is knowledgeable about the collection, analysis, and use of health care
487 data;
488 (b) [one physician] two physicians, as defined in Section 58-67-102[,]:
489 (i) who are licensed to practice in this state[, who spends the majority of his time in the
490 practice of];

491 (ii) who actively practice medicine in this state;
492 (iii) who are trained in or have experience with the collection, analysis, and use of
493 health care data; and
494 (iv) one of whom is selected by the Utah Medical Association;
495 (c) one registered nurse licensed to practice in this state under Title 58, Chapter 31b,
496 Nurse Practice Act, who is trained in or has experience with the collection, analysis, and use of
497 health care data;
498 (d) (i) three persons who are:
499 (A) employed by or otherwise associated with a business that supplies health care
500 insurance to its employees[,]; and
501 (B) knowledgeable about the collection and use of health care data; and
502 (ii) at least one of whom represents an employer employing 50 or fewer employees;
503 (e) one person employed by or associated with a third-party payor that is not licensed
504 under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans who
505 is trained in, or experienced with the collection, analysis, and use of health care data;
506 (f) [two] one consumer [representatives] representative:
507 (i) from organized consumer or employee associations; and
508 (ii) knowledgeable about the collection and use of health care data;
509 (g) one person [broadly]:
510 (i) representative of [the public interest;] a neutral, non-biased entity that can
511 demonstrate that is has the broad support of health care payers and health care providers; and
512 (ii) who is knowledgeable about the collection, analysis and use of health care data;
513 (h) one person employed by or associated with an organization that is licensed under
514 Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans who is
515 knowledgeable about the collection, analysis and use of health care data; and
516 (i) two [people] persons representing public health who are trained in, or experienced
517 with the collection, use, and analysis of health care data.
518 (5) (a) Except as required by Subsection (5)(b), as terms of current committee members
519 expire, the governor shall appoint each new member or reappointed member to a four-year
520 term.
521 (b) Notwithstanding the requirements of Subsection (5)(a), the governor shall[,]:

522 (i) at the time of appointment or reappointment, adjust the length of terms to ensure
523 that the terms of committee members are staggered so that approximately half of the committee
524 is appointed every two years[.]; and
525 (ii) prior to October 1, 2011, re-appoint the members described in Subsections(4)(d),
526 (e), (f). (g) and (h) as necessary to comply with changes in eligibility for membership that were
527 enacted during the 2011 General Session.
528 (c) Members may serve after their terms expire until replaced.
529 (6) When a vacancy occurs in the membership for any reason, the replacement shall be
530 appointed for the unexpired term.
531 (7) Committee members shall annually elect a chair of the committee from among their
532 membership. The chair shall report to the executive director.
533 (8) The committee shall meet at least once during each calendar quarter. Meeting dates
534 shall be set by the chair upon 10 working days notice to the other members, or upon written
535 request by at least four committee members with at least 10 working days notice to other
536 committee members.
537 (9) Seven committee members constitute a quorum for the transaction of business.
538 Action may not be taken except upon the affirmative vote of a majority of a quorum of the
539 committee.
540 (10) A member may not receive compensation or benefits for the member's service, but
541 may receive per diem and travel expenses in accordance with:
542 (a) Section 63A-3-106;
543 (b) Section 63A-3-107; and
544 (c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and
545 63A-3-107.
546 (11) All meetings of the committee shall be open to the public, except that the
547 committee may hold a closed meeting if the requirements of Sections 52-4-204, 52-4-205, and
548 52-4-206 are met.
549 Section 6. Section **26-33a-106.5** is amended to read:
550 **26-33a-106.5. Comparative analyses.**
551 (1) The committee may publish compilations or reports that compare and identify
552 health care providers or data suppliers from the data it collects under this chapter or from any

553 other source.

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

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

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

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

560 (i) be published at least annually; and

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

562 (A) nationally or other generally recognized quality standards;

563 (B) charges; and

564 (C) nationally recognized patient safety standards.

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

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

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

576 (a) free of charge and easily accessible to the public[.]; and

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

578 (6) (a) On or before October 1, 2011, the department shall include in the report
579 required by Subsection (2)(b), or include in a separate report, comparative information on:

580 (i) a minimum of 14 commonly recognized or generally agreed upon measures of
581 quality identified in accordance with Subsection (7), for:

582 (A) routine and preventive care; and

583 (B) the treatment of diabetes, heart disease, and other illnesses or conditions; and

584 (ii) facilities identified in Subsection (2)(a)(ii) and clinic level physician data as
585 required by Subsection (6)(b).
586 (b) The comparative information required by Subsection (6)(a) shall be based on data
587 collected under Subsection (2) and clinical data that may be available to the committee, and
588 shall:
589 (i) by October 1, 2011, be reported as a statewide aggregate for:
590 (A) facilities; and
591 (B) physicians; and
592 (ii) for reports on or after July 1, 2012, be reported:
593 (A) by a health care facility or institution;
594 (B) as a clinic's aggregate results for a physician who practices at a clinic with five or
595 more physicians; and
596 (C) as a geographic region's aggregate results for a physician who practices at a clinic
597 with less than five physicians, unless the physician requests physician-level data to be
598 published on a clinic level under Subsection (6)(b)(ii)(B).
599 (c) The department:
600 (i) may publish information required by this Subsection (6) directly or through one or
601 more nonprofit, community-based health data organizations;
602 (ii) may use a private, independent analyst under Subsection (3) in preparing the report
603 required by this section; and
604 (iii) shall identify and report to the Legislature's Health and Human Services Interim
605 Committee by July 1, 2012, and every July 1, thereafter until July 1, 2015, at least five new
606 measures of quality to be added to the report each year.
607 (d) A report published by the department under this Subsection (6):
608 (i) is subject to the requirements of Section 26-33a-107; and
609 (ii) shall, prior to being published by the department, be submitted to a neutral,
610 non-biased entity with a broad base of support from health care payers and health care
611 providers in accordance with Subsection (7).
612 (7) (a) The Health Data Committee shall, through the department, for purposes of
613 Subsection (6)(a)(i), use the 14 quality measures that are developed and agreed upon by a
614 neutral, non-biased entity with a broad base of support from health care payers and health care

615 providers.
616 (b) If the entity described in Subsection (7)(a) does not submit 14 quality measures
617 prior to July 1, 2011, the department may select the 14 quality measures for purposes of the
618 report required by Subsection (6).
619 Section 7. Section **26-40-106** is amended to read:
620 **26-40-106. Program benefits.**
621 (1) Until the department implements a plan under Subsection (2), program benefits
622 may include:
623 (a) hospital services;
624 (b) physician services;
625 (c) laboratory services;
626 (d) prescription drugs;
627 (e) mental health services;
628 (f) basic dental services;
629 (g) preventive care including:
630 (i) routine physical examinations;
631 (ii) immunizations;
632 (iii) basic vision services; and
633 (iv) basic hearing services;
634 (h) limited home health and durable medical equipment services; and
635 (i) hospice care.
636 (2) (a) Except as provided in Subsection (2)[~~(c)~~](d), no later than July 1, 2008, the
637 program benefits shall be benchmarked, in accordance with 42 U.S.C. 1397cc, to be actuarially
638 equivalent to a health benefit plan with the largest insured commercial enrollment offered by a
639 health maintenance organization in the state.
640 (b) Except as provided in Subsection (2)[~~(c)~~](d), after July 1, 2008:
641 (i) program benefits may not exceed the benefit level described in Subsection (2)(a);
642 and
643 (ii) program benefits shall be adjusted every July 1, thereafter to meet the benefit level
644 described in Subsection (2)(a).
645 (c) The dental benefit plan shall be benchmarked, in accordance with the Children's

646 Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit
647 plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is
648 offered in the state.
649 [(c)] (d) The program benefits for enrollees who are at or below 100% of the federal
650 poverty level are exempt from the benchmark requirements of Subsections (2)(a) and (2)(b).
651 Section 8. Section **26-40-115** is enacted to read:
652 **26-40-115. State contractor -- Employee and dependent health benefit plan**
653 **coverage.**
654 For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205, 63C-9-403, 72-6-107.5,
655 and 79-2-404, "qualified health insurance coverage" means at the time the contract is entered
656 into or renewed:
657 (1) a health benefit plan and employer contribution level with a combined actuarial
658 value at least actuarially equivalent to the combined actuarial value of the benchmark plan
659 determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and
660 a contribution level of 50% of the premium for the employee and the dependents of the
661 employee who reside or work in the state, in which:
662 (a) the employer pays at least 50% of the premium for the employee and the
663 dependents of the employee who reside or work in the state; and
664 (b) for purposes of calculating actuarial equivalency under this Subsection (1)(b):
665 (i) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket
666 maximum based on income levels:
667 (A) the deductible is $1,000 per individual and $3,000 per family; and
668 (B) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;
669 (ii) dental coverage is not required; and
670 (iii) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
671 apply; or
672 (2) a federally qualified high deductible health plan that, at a minimum:
673 (a) has a deductible that is either:
674 (i) the lowest deductible permitted for a federally qualified high deductible health plan;
675 or
676 (ii) a deductible that is higher than the lowest deductible permitted for a federally

677 qualified high deductible health plan, but includes an employer contribution to a health savings
678 account in a dollar amount at least equal to the dollar amount difference between the lowest
679 deductible permitted for a federally qualified high deductible plan and the deductible for the
680 employer offered federally qualified high deductible plan;
681 (b) has an out-of-pocket maximum that does not exceed three times the amount of the
682 annual deductible; and
683 (c) the employer pays 60% of the premium for the employee and the dependents of the
684 employee who work or reside in the state.
685 Section 9. Section **31A-2-212** is amended to read:
686 **31A-2-212. Miscellaneous duties.**
687 (1) Upon issuance of any order limiting, suspending, or revoking an insurer's authority
688 to do business in Utah, and on institution of any proceedings against the insurer under Chapter
689 27a, Insurer Receivership Act, the commissioner:
690 (a) shall notify by mail all agents of the insurer of whom the commissioner has record;
691 and
692 (b) may publish notice of the order or proceeding in any manner the commissioner
693 considers necessary to protect the rights of the public.
694 (2) When required for evidence in any legal proceeding, the commissioner shall furnish
695 a certificate of the authority of any licensee to transact insurance business in Utah on any
696 particular date. The court or other officer shall receive the certificate of authority in lieu of the
697 commissioner's testimony.
698 (3) (a) On the request of any insurer authorized to do a surety business, the
699 commissioner shall furnish a copy of the insurer's certificate of authority to any designated
700 public officer in this state who requires that certificate of authority before accepting a bond.
701 (b) The public officer described in Subsection (3)(a) shall file the certificate of
702 authority furnished under Subsection (3)(a).
703 (c) After a certified copy of a certificate of authority has been furnished to a public
704 officer, it is not necessary, while the certificate of authority remains effective, to attach a copy
705 of it to any instrument of suretyship filed with that public officer.
706 (d) Whenever the commissioner revokes the certificate of authority or starts
707 proceedings under Chapter 27a, Insurer Receivership Act, against any insurer authorized to do

708 a surety business, the commissioner shall immediately give notice of that action to each public
709 officer who was sent a certified copy under this Subsection (3).
710 (4) (a) The commissioner shall immediately notify every judge and clerk of all courts
711 of record in the state when:
712 (i) an authorized insurer doing a surety business:
713 (A) files a petition for receivership; or
714 (B) is in receivership; or
715 (ii) the commissioner has reason to believe that the authorized insurer doing surety
716 business:
717 (A) is in financial difficulty; or
718 (B) has unreasonably failed to carry out any of its contracts.
719 (b) Upon the receipt of the notice required by this Subsection (4) it is the duty of the
720 judges and clerks to notify and require every person that has filed with the court a bond on
721 which the authorized insurer doing surety business is surety, to immediately file a new bond
722 with a new surety.
723 (5) The commissioner shall require an insurer that issues, sells, renews, or offers health
724 insurance coverage in this state to comply with:
725 (a) the Health Insurance Portability and Accountability Act, [~~P.L. 104-191~~] Pub. L. No.
726 104-191, pursuant to 110 Stat. 1968, Sec. 2722[.]; and
727 (b) subject to Section 63M-1-2505.5, and to the extent required or applicable under the
728 provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the
729 Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, related to regulation
730 of health benefit plans, including:
731 (i) lifetime and annual limits;
732 (ii) prohibition of rescissions;
733 (iii) coverage of preventive health services;
734 (iv) coverage for a child or dependent;
735 (v) pre-existing condition coverage for children;
736 (vi) insurer transparency of consumer information including plan disclosures, uniform
737 coverage documents, and standard definitions;
738 (vii) premium rate reviews;

739 (viii) essential benefits;
740 (ix) provider choice;
741 (x) waiting periods; and
742 (xi) appeals processes.
743 Section 10. Section **31A-22-613.5** is amended to read:
744 **31A-22-613.5. Price and value comparisons of health insurance.**
745 (1) (a) This section applies to all health benefit plans.
746 (b) Subsection (2) applies to:
747 (i) all health benefit plans; and
748 (ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
749 (2) (a) The commissioner shall promote informed consumer behavior and responsible
750 health benefit plans by requiring an insurer issuing a health benefit plan to:
751 (i) provide to all enrollees, prior to enrollment in the health benefit plan written
752 disclosure of:
753 (A) restrictions or limitations on prescription drugs and biologics including:
754 (I) the use of a formulary;
755 (II) co-payments and deductibles for prescription drugs; and
756 (III) requirements for generic substitution;
757 (B) coverage limits under the plan; and
758 (C) any limitation or exclusion of coverage including:
759 (I) a limitation or exclusion for a secondary medical condition related to a limitation or
760 exclusion from coverage; and
761 (II) easily understood examples of a limitation or exclusion of coverage for a secondary
762 medical condition; and
763 (ii) provide the commissioner with:
764 (A) the information described in Subsections [~~63M-1-2506(3) through (6)~~]
765 31A-22-635(5) through (7) in the standardized electronic format required by Subsection
766 63M-1-2506(1); and
767 (B) information regarding insurer transparency in accordance with Subsection [~~(5)~~] (4).
768 (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to
769 the commissioner:

770 (i) upon commencement of operations in the state; and
771 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
772 (A) treatment policies;
773 (B) practice standards;
774 (C) restrictions;
775 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
776 (E) limitations or exclusions of coverage including a limitation or exclusion for a
777 secondary medical condition related to a limitation or exclusion of the insurer's health
778 insurance plan.
779 (c) An insurer shall provide the enrollee with notice of an increase in costs for
780 prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):
781 (i) either:
782 (A) in writing; or
783 (B) on the insurer's website; and
784 (ii) at least 30 days prior to the date of the implementation of the increase in cost, or as
785 soon as reasonably possible.
786 (d) If under Subsection (2)(a)(i)(A) a formulary is used, the insurer shall make
787 available to prospective enrollees and maintain evidence of the fact of the disclosure of:
788 (i) the drugs included;
789 (ii) the patented drugs not included;
790 (iii) any conditions that exist as a precedent to coverage; and
791 (iv) any exclusion from coverage for secondary medical conditions that may result
792 from the use of an excluded drug.
793 (e) (i) The [~~department~~] commissioner shall develop examples of limitations or
794 exclusions of a secondary medical condition that an insurer may use under Subsection
795 (2)(a)(i)(C).
796 (ii) Examples of a limitation or exclusion of coverage provided under Subsection
797 (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact
798 situation to fall within the description of an example does not, by itself, support a finding of
799 coverage.
800 [~~(3) An insurer who offers a health benefit plan under Chapter 30, Individual, Small~~

801 Employer, and Group Health Insurance Act, shall offer a basic health care plan subject to the
802 open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health
803 Insurance Act, that:]
804 [(a) is a federally qualified high deductible health plan;]
805 [(b) has a deductible that is within $250 of the lowest deductible that qualifies under a
806 federally qualified high deductible health plan, as adjusted by federal law; and]
807 [(c) does not exceed an annual out of pocket maximum equal to three times the amount
808 of the annual deductible.]
809 [(4)] (3) The commissioner:
810 (a) shall forward the information submitted by an insurer under Subsection (2)(a)(ii) to
811 the Health Insurance Exchange created under Section 63M-1-2504; and
812 (b) may request information from an insurer to verify the information submitted by the
813 insurer under this section.
814 [(5)] (4) The commissioner shall:
815 (a) convene a group of insurers, a member representing the Public Employees' Benefit
816 and Insurance Program, consumers, and an organization described in Subsection
817 31A-22-614.6(3)(b), to develop information for consumers to compare health insurers and
818 health benefit plans on the Health Insurance Exchange, which shall include consideration of:
819 (i) the number and cost of an insurer's denied health claims;
820 (ii) the cost of denied claims that is transferred to providers;
821 (iii) the average out-of-pocket expenses incurred by participants in each health benefit
822 plan that is offered by an insurer in the Health Insurance Exchange;
823 (iv) the relative efficiency and quality of claims administration and other administrative
824 processes for each insurer offering plans in the Health Insurance Exchange; and
825 (v) consumer assessment of each insurer or health benefit plan;
826 (b) adopt an administrative rule that establishes:
827 (i) definition of terms;
828 (ii) the methodology for determining and comparing the insurer transparency
829 information;
830 (iii) the data, and format of the data, that an insurer must submit to the [department]
831 commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange

832 in accordance with Section 63M-1-2506; and

833 (iv) the dates on which the insurer must submit the data to the [department]

834 commissioner in order for the [department] commissioner to transmit the data to the Health

835 Insurance Exchange in accordance with Section 63M-1-2506; and

836 (c) implement the rules adopted under Subsection [(5)] (4)(b) in a manner that protects

837 the business confidentiality of the insurer.

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

839 **31A-22-614.6. Health care delivery and payment reform demonstration projects.**

840 (1) The Legislature finds that:

841 (a) current health care delivery and payment systems do not provide systemwide

842 aligned incentives for the appropriate delivery of health care;

843 (b) some health care providers and health care payers have developed ideas for health

844 care delivery and payment system reform, but lack the critical number of patient lives and

845 payer involvement to accomplish systemwide reform; and

846 (c) there is a compelling state interest to encourage [as many] health care providers and

847 health care payers to join together and coordinate efforts at systemwide health care delivery and

848 payment reform.

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

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

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

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

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

854 (b) (i) The speaker of the House of Representatives may appoint a person who is a

855 member of the House of Representatives, or from the Office of Legislative Research and

856 General Counsel, to attend the meetings convened under Subsection (2)(a).

857 (ii) The president of the Senate may appoint a person who is a senator, or from the

858 Office of Legislative Research and General Counsel, to attend the meetings convened under

859 Subsection (2)(a).

860 (c) Participation in the coordination efforts by health care providers and health care

861 payers is voluntary, but is encouraged.

862 (3) The commissioner and the [Office of Consumer Health Services shall] Department

863 of Health may facilitate several coordinated broad based demonstration projects for health care
864 delivery reform and health care payment reform between one or more health care providers and
865 one or more health care payers who elect to participate in the demonstration projects by:
866 (a) consulting with health care providers and health care payers who elect to join
867 together in a broad based reform demonstration project;
868 (b) consulting with a neutral, non-biased third party with an established record for
869 broad based, multi-payer and multi-provider quality assurance efforts and data collection;
870 (c) applying for grants and assistance that may be available for creating and
871 implementing the demonstration projects; and
872 (d) adopting administrative rules in accordance with Title 63G, Chapter 3, Utah
873 Administrative Rulemaking Act, as necessary to develop, oversee, and implement the
874 demonstration projects.
875 (4) The [~~Office of Consumer Health Services~~] Department of Health and the
876 commissioner shall report to the Health System Reform Task Force by October [~~2010~~] 2011,
877 and to the Legislature's Business and Labor Interim Committee every October thereafter
878 regarding the progress towards coordination of broad based health care system payment and
879 delivery reform.
880 Section 12. Section **31A-22-635** is amended to read:
881 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**
882 **on Health Insurance Exchange.**
883 (1) For purposes of this section, "insurer":
884 (a) is defined in Subsection 31A-22-634(1); and
885 (b) includes the state employee's risk pool under Section 49-20-202.
886 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall[~~:~~
887 ~~(i) except as provided in Subsection (6),~~] use a uniform application form[~~, which, beginning~~
888 ~~October 1, 2010:~~].
889 (b) The uniform application form:
890 [~~(A)~~] (i) except for cancer and transplants, may not include questions about an
891 applicant's health history prior to the previous [~~10~~] five years; and
892 [~~(B)~~] (ii) shall be shortened and simplified in accordance with rules adopted by the
893 [~~department; and~~] commissioner.

894 [(ii)] (c) Insurers offering a health benefit plan to a small employer shall use a uniform
895 waiver of coverage form, which[: (A)] may not include health status related questions other
896 than pregnancy[;], and [(B)] is limited to:
897 [(I)] (i) information that identifies the employee;
898 [(II)] (ii) proof of the employee's insurance coverage; and
899 [(III)] (iii) a statement that the employee declines coverage with a particular employer
900 group.
901 [(b)] (3) Notwithstanding the requirements of Subsection (2)(a), the uniform
902 application and uniform waiver of coverage forms may be combined or modified to facilitate[:]
903 a more efficient and consumer friendly experience for enrollees using the Health Insurance
904 Exchange if the modification is approved by the commissioner.
905 [(i) the electronic submission and processing of an application through the Health
906 Insurance Exchange created pursuant to Section 63M-1-2504 or directly to all carriers; and]
907 [(ii) a more efficient and understandable experience for a consumer submitting an
908 application in the Health Insurance Exchange or directly to all carriers.]
909 [(3) An insurer offering a defined contribution arrangement health benefit plan in the
910 Health Insurance Exchange to a large group shall use a large group uniform application, and
911 uniform waiver of coverage form, that is adopted by the department by administrative rule.]
912 (4) [(a) (i)] The uniform application form, and uniform waiver form, shall be adopted
913 and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah
914 Administrative Rulemaking Act.
915 [(ii) Modifications to the uniform application necessary to facilitate the electronic
916 submission and processing of an application through the Health Insurance Exchange shall be
917 adopted by administrative rule adopted by the Office of Consumer Health Services in
918 accordance with Section 63M-1-2506.]
919 [(b) The commissioner shall convene the health insurance industry, the Office of
920 Consumer Health Services, and consumers to review the uniform application for the individual
921 and small group market, and the large group market, and make recommendations regarding the
922 uniform applications. The department shall report the findings of the group convened pursuant
923 to this Subsection (4)(b) to the Legislature no later than July 1, 2010.]
924 (5) (a) [Beginning October 1, 2010, an] An insurer who offers a health benefit plan in

925 either the group or individual market on the Health Insurance Exchange created in Section
926 63M-1-2504, shall:
927 (i) accept and process an electronic submission of the uniform application or uniform
928 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
929 Section 63M-1-2506; [and]
930 (ii) if requested, provide the applicant with a copy of the completed application either
931 by mail or electronically[.];
932 (iii) post all health benefit plans offered by the insurer in the defined contribution
933 arrangement market on the Health Insurance Exchange; and
934 (iv) post the information required by Subsection (6) on the Health Insurance Exchange
935 for every health benefit plan the insurer offers on the Health Insurance Exchange.
936 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans
937 on the Health Insurance Exchange may not directly or indirectly offer products on the Health
938 Insurance Exchange that are not health benefit plans.
939 (c) Notwithstanding Subsection (5)(b), an insurer may offer a health savings account
940 on the Health Insurance Exchange.
941 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with
942 the following information for each health benefit plan submitted to the Health Insurance
943 Exchange, in the electronic format required by Subsection 63M-1-2506(1):
944 (a) plan design, benefits, and options offered by the health benefit plan including state
945 mandates the plan does not cover;
946 (b) information and Internet address to online provider networks;
947 (c) wellness programs and incentives;
948 (d) descriptions of prescription drug benefits, exclusions, or limitations;
949 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is
950 submitted to the insurer for the prior year; and
951 (f) the claims denial and insurer transparency information developed in accordance
952 with Subsection 31A-22-613.5(4).
953 (7) The Insurance Department shall post on the Health Insurance Exchange the
954 Insurance Department's solvency rating for each insurer who posts a health benefit plan on the
955 Health Insurance Exchange. The solvency rating for each insurer shall be based on

956 methodology established by the Insurance Department by administrative rule and shall be
957 updated each calendar year.
958 (8) (a) The commissioner may request information from an insurer under Section
959 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health
960 Insurance Exchange.
961 (b) The commissioner shall regulate any fees charged by insurers to an enrollee for a
962 uniform application form or electronic submission of the application forms.
963 [~~(6) An insurer offering a health benefit plan outside the Health Insurance Exchange~~
964 ~~may use the uniform application in effect prior to May 15, 2010, until January 1, 2011.~~]
965 Section 13. Section **31A-22-724** is amended to read:
966 **31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**
967 (1) For purposes of this section, "alternative coverage" means:
968 (a) [~~the~~] a high deductible or low deductible Utah NetCare Plan described in
969 Subsection (2) for a conversion [~~policies~~] health benefit plan policy offered under Section
970 31A-22-723; and
971 (b) [~~the~~] a high deductible and low deductible Utah NetCare Plans described in
972 Subsection (2) as an alternative to COBRA and mini-COBRA [~~policies~~] health benefit plan
973 coverage offered under Section 31A-22-722.
974 (2) [~~The~~] A Utah NetCare [~~Plans~~] Plan under this section is subject to Section
975 31A-2-212 and shall, except when prohibited by federal law, include:
976 (a) healthy lifestyle and wellness incentives;
977 (b) the benefits described in this Subsection (2) or at least the actuarial equivalent of
978 the benefits described in this Subsection (2);
979 (c) a lifetime maximum benefit per person of not less than $1,000,000;
980 (d) an annual maximum benefit per person of not less than $250,000;
981 (e) the following deductibles:
982 (i) for [~~the~~] a low deductible [~~plans~~] plan:
983 (A) $2,000 for an individual plan;
984 (B) $4,000 for a two party plan; and
985 (C) $6,000 for a family plan;
986 (ii) for [~~the~~] a high deductible [~~plans~~] plan:

987 (A) $4,000 for an individual plan;
988 (B) $8,000 for a two party plan; and
989 (C) $12,000 for a family plan;
990 (f) the following out-of-pocket maximum costs, including deductibles, copayments,
991 and coinsurance:
992 (i) for [the] a low deductible [plans] plan:
993 (A) $5,000 for an individual plan;
994 (B) $10,000 for a two party plan; and
995 (C) $15,000 for a family plan; and
996 (ii) for [the] a high deductible plan:
997 (A) $10,000 for an individual plan;
998 (B) $20,000 for a two party plan; and
999 (C) $30,000 for a family plan;
1000 (g) the following benefits before applying [any] a deductible [requirements]
1001 requirement and in accordance with [IRC] Section 223, Internal Revenue Code, and 42 U.S.C.
1002 Sec. 300gg-13:
1003 (i) all well child exams and immunizations up to age five, with no annual maximum;
1004 (ii) preventive care up to a $500 annual maximum;
1005 (iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i)
1006 or (ii) up to a $300 annual maximum; and
1007 (iv) supplemental accident coverage up to a $500 annual maximum;
1008 (h) the following copayments for each exam:
1009 (i) $15 for preventive care and well child exams;
1010 (ii) $25 for primary care; and
1011 (iii) $50 for urgent care and specialist care;
1012 (i) a $200 copayment for an emergency room [visits] visit after applying the
1013 deductible;
1014 (j) no more than a 30% coinsurance after deductible for covered plan benefits for:
1015 (i) hospital services[,];
1016 (ii) maternity[,];
1017 (iii) laboratory work[,];

1018 (iv) x-rays[;];
1019 (v) radiology[;];
1020 (vi) outpatient surgery services[;];
1021 (vii) injectable medications not otherwise covered under a pharmacy benefit[;];
1022 (viii) durable medical equipment[;];
1023 (ix) ambulance services[;];
1024 (x) in-patient mental health services[;]; and
1025 (xi) out-patient mental health services; and
1026 (k) the following cost-sharing features for a prescription [drugs] drug:
1027 (i) up to a $15 copayment for a generic [drugs;] drug; and
1028 (ii) up to a 50% coinsurance for a name brand [drugs; and] drug.
1029 [(iii) may include formularies and preferred drug lists.]
1030 (3) [The] A Utah NetCare [Plans] Plan may exclude:
1031 (a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and
1032 (b) unless required by federal law, mandated coverage required by the following
1033 sections and related administrative rules:
1034 (i) Section 31A-22-610.1, Adoption indemnity [benefits] benefit;
1035 (ii) Section 31A-22-623, Coverage of inborn metabolic errors;
1036 (iii) Section 31A-22-624, Primary care [physicians] physician;
1037 (iv) Section 31A-22-626, Coverage of diabetes;
1038 (v) Section 31A-22-628, Standing referral to a specialist; and
1039 (vi) [coverage mandates] a mandated coverage enacted after January 1, 2009, that [are]
1040 is not required by federal law.
1041 [(4) (a) Beginning January 1, 2010, and except]
1042 (4) A Utah NetCare Plan may include a formulary or preferred drug list.
1043 (5) (a) Except as provided in Subsection [(5)] (6), a person may elect alternative
1044 coverage under this section if the person is eligible for:
1045 (i) [is eligible for] continuation of employer group health benefit plan coverage under
1046 federal COBRA laws;
1047 (ii) [is eligible for] continuation of employer group health benefit plan coverage under
1048 state mini-COBRA under Section 31A-22-722; or

1049 (iii) [is eligible for] a conversion to an individual health benefit plan after the
1050 exhaustion of benefits under:
1051 (A) alternative coverage elected in place of federal COBRA; or
1052 (B) state mini-COBRA under Section 31A-22-722.
1053 (b) The right to extend coverage under Subsection [(4)] (5)(a) applies to [any] spouse
1054 or dependent coverages, including a surviving spouse or dependent whose coverage under the
1055 policy terminates by reason of the death of the employee or member.
1056 [(5)] (6) If a person elects federal COBRA [coverage,] or state mini-COBRA health
1057 benefit plan coverage under Section 31A-22-722, the person is not eligible to elect alternative
1058 coverage under this section until the person is eligible to convert coverage to an individual
1059 policy under [the provisions of] Section 31A-22-723 and Subsection (1)(a).
1060 [(6)] (7) (a) (i) If [the] alternative coverage is selected as an alternative to COBRA or
1061 mini-COBRA health benefit plan coverage under Section 31A-22-722, [the provisions of]
1062 Section 31A-22-722 [apply] applies to the alternative coverage.
1063 (ii) If an employee of a small employer selects alternative coverage as an alternative to
1064 COBRA or mini-COBRA health benefit plan coverage, the insurer may not use a risk factor
1065 greater than the employer's most current risk factor for purposes of Subsection 31A-22-722(5).
1066 (b) If [the] alternative coverage is selected as a conversion policy under Section
1067 31A-22-723, [the provisions of] Section 31A-22-723 [apply] applies.
1068 [(7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to
1069 September 1, 2009, file an alternative coverage policy with the department in accordance with
1070 Sections 31A-21-201 and 31A-21-201.1.]
1071 [(b)] (8) The [department] commissioner shall[, by November 1, 2009,] adopt
1072 administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
1073 Act, to develop a model letter for employers to use to notify an employee of the employee's
1074 options for alternative coverage.
1075 Section 14. Section **31A-23a-115.5** is enacted to read:
1076 **31A-23a-115.5. Use of customer service representative.**
1077 A customer service representative licensed under this chapter:
1078 (1) may not maintain an office independent of the customer service representative's
1079 licensed producer or consultant employer for the purpose of conducting insurance activities;

1080 (2) except as provided in Subsection (3), may not sell, solicit, negotiate, or bind
1081 coverage; and
1082 (3) may provide a customer a quote on behalf of the customer service representative's
1083 licensed producer or consultant employer.
1084 Section 15. Section **31A-29-103** is amended to read:
1085 **31A-29-103. Definitions.**
1086 As used in this chapter:
1087 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.
1088 (2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.
1089 (b) "Creditable coverage" does not include a period of time in which there is a
1090 significant break in coverage, as defined in Section 31A-1-301.
1091 (3) "Domicile" means the place where an individual has a fixed and permanent home
1092 and principal establishment:
1093 (a) to which the individual, if absent, intends to return; and
1094 (b) in which the individual, and the individual's family voluntarily reside, not for a
1095 special or temporary purpose, but with the intention of making a permanent home.
1096 (4) "Enrollee" means an individual who has met the eligibility requirements of the pool
1097 and is covered by a pool policy under this chapter.
1098 (5) "Health benefit plan":
1099 (a) is defined in Section 31A-1-301; and
1100 (b) does not include a plan that:
1101 (i) (A) has a maximum actuarial value less [~~that~~] than 100% of [~~the basic health care~~
1102 ~~plan; or~~] a health benefit plan described in Subsection (5)(c); or
1103 (B) has a maximum annual limit of $100,000 or less; and
1104 (ii) meets other criteria established by the board.
1105 (c) For purposes of Subsection (5)(b)(i)(A) the health benefit plan shall:
1106 (i) be a federally qualified high deductible health plan;
1107 (ii) have a deductible that has the lowest deductible that qualifies as a federally
1108 qualified high deductible health plan as adjusted by federal law; and
1109 (iii) not exceed an annual out-of-pocket maximum equal to three times the amount of
1110 the deductible.

1111 (6) "Health care facility" means any entity providing health care services which is
1112 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.
1113 (7) "Health care insurance" is defined in Section 31A-1-301.
1114 (8) "Health care provider" has the same meaning as provided in Section 78B-3-403.
1115 (9) "Health care services" means:
1116 (a) any service or product:
1117 (i) used in furnishing to any individual medical care or hospitalization; or
1118 (ii) incidental to furnishing medical care or hospitalization; and
1119 (b) any other service or product furnished for the purpose of preventing, alleviating,
1120 curing, or healing human illness or injury.
1121 (10) "Health maintenance organization" has the same meaning as provided in Section
1122 31A-8-101.
1123 (11) "Health plan" means any arrangement by which an individual, including a
1124 dependent or spouse, covered or making application to be covered under the pool has:
1125 (a) access to hospital and medical benefits or reimbursement including group or
1126 individual insurance or subscriber contract;
1127 (b) coverage through:
1128 (i) a health maintenance organization;
1129 (ii) a preferred provider prepayment;
1130 (iii) group practice;
1131 (iv) individual practice plan; or
1132 (v) health care insurance;
1133 (c) coverage under an uninsured arrangement of group or group-type contracts
1134 including employer self-insured, cost-plus, or other benefits methodologies not involving
1135 insurance;
1136 (d) coverage under a group type contract which is not available to the general public
1137 and can be obtained only because of connection with a particular organization or group; and
1138 (e) coverage by Medicare or other governmental benefit.
1139 (12) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996,
1140 Pub. L. 104-191, 110 Stat. 1936.
1141 (13) "HIPAA eligible" means an individual who is eligible under the provisions of the

1142 Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.
1143 (14) "Insurer" means:
1144 (a) an insurance company authorized to transact accident and health insurance business
1145 in this state;
1146 (b) a health maintenance organization; or
1147 (c) a self-insurer not subject to federal preemption.
1148 (15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.
1149 Sec. 1396 et seq., as amended.
1150 (16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social
1151 Security Act, 42 U.S.C. 1395 et seq., as amended.
1152 (17) "Plan of operation" means the plan developed by the board in accordance with
1153 Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board
1154 under Section 31A-29-106.
1155 (18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section
1156 31A-29-104.
1157 (19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund
1158 created in Section 31A-29-120.
1159 (20) "Pool policy" means a health benefit plan policy issued under this chapter.
1160 (21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.
1161 (22) (a) "Resident" or "residency" means a person who is domiciled in this state.
1162 (b) A resident retains residency if that resident leaves this state:
1163 (i) to serve in the armed forces of the United States; or
1164 (ii) for religious or educational purposes.
1165 (23) "Third party administrator" has the same meaning as provided in Section
1166 31A-1-301.
1167 Section 16. Section **31A-30-103** is amended to read:
1168 **31A-30-103. Definitions.**
1169 As used in this chapter:
1170 (1) "Actuarial certification" means a written statement by a member of the American
1171 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
1172 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,

1173 including review of the appropriate records and of the actuarial assumptions and methods used
1174 by the covered carrier in establishing premium rates for applicable health benefit plans.
1175 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
1176 through one or more intermediaries, controls or is controlled by, or is under common control
1177 with, a specified entity or person.
1178 (3) "Base premium rate" means, for each class of business as to a rating period, the
1179 lowest premium rate charged or that could have been charged under a rating system for that
1180 class of business by the covered carrier to covered insureds with similar case characteristics for
1181 health benefit plans with the same or similar coverage.
1182 (4) "Basic benefit plan" or "basic coverage" means [~~the coverage provided in the Basic~~
1183 ~~Health Care Plan under Section 31A-22-613.5.~~] a health benefit plan that:
1184 (a) until January 1, 2012:
1185 (i) is a federally qualified high deductible health plan;
1186 (ii) has a deductible that has the lowest deductible that qualifies as a federally qualified
1187 high deductible health plan as adjusted by federal law; and
1188 (iii) does not exceed an annual out-of-pocket maximum equal to three times the
1189 amount of the deductible; and
1190 (b) on or after January 1, 2012, is actuarially equivalent to NetCare as provided in
1191 Section 31A-22-724.
1192 (5) "Carrier" means any person or entity that provides health insurance in this state
1193 including:
1194 (a) an insurance company;
1195 (b) a prepaid hospital or medical care plan;
1196 (c) a health maintenance organization;
1197 (d) a multiple employer welfare arrangement; and
1198 (e) any other person or entity providing a health insurance plan under this title.
1199 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
1200 demographic or other objective characteristics of a covered insured that are considered by the
1201 carrier in determining premium rates for the covered insured.
1202 (b) "Case characteristics" do not include:
1203 (i) duration of coverage since the policy was issued;

1204 (ii) claim experience; and
1205 (iii) health status.
1206 (7) "Class of business" means all or a separate grouping of covered insureds that is
1207 permitted by the department in accordance with Section 31A-30-105.
1208 (8) "Conversion policy" means a policy providing coverage under the conversion
1209 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.
1210 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
1211 this chapter.
1212 (10) "Covered individual" means any individual who is covered under a health benefit
1213 plan subject to this chapter.
1214 (11) "Covered insureds" means small employers and individuals who are issued a
1215 health benefit plan that is subject to this chapter.
1216 (12) "Dependent" means an individual to the extent that the individual is defined to be
1217 a dependent by:
1218 (a) the health benefit plan covering the covered individual; and
1219 (b) Chapter 22, Part 6, Accident and Health Insurance.
1220 (13) "Established geographic service area" means a geographical area approved by the
1221 commissioner within which the carrier is authorized to provide coverage.
1222 (14) "Index rate" means, for each class of business as to a rating period for covered
1223 insureds with similar case characteristics, the arithmetic average of the applicable base
1224 premium rate and the corresponding highest premium rate.
1225 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
1226 through a health benefit plan regardless of whether:
1227 (a) coverage is offered through:
1228 (i) an association;
1229 (ii) a trust;
1230 (iii) a discretionary group; or
1231 (iv) other similar groups; or
1232 (b) the policy or contract is situated out-of-state.
1233 (16) "Individual conversion policy" means a conversion policy issued to:
1234 (a) an individual; or

1235 (b) an individual with a family.
1236 (17) "Individual coverage count" means the number of natural persons covered under a
1237 carrier's health benefit products that are individual policies.
1238 (18) "Individual enrollment cap" means the percentage set by the commissioner in
1239 accordance with Section 31A-30-110.
1240 (19) "New business premium rate" means, for each class of business as to a rating
1241 period, the lowest premium rate charged or offered, or that could have been charged or offered,
1242 by the carrier to covered insureds with similar case characteristics for newly issued health
1243 benefit plans with the same or similar coverage.
1244 (20) "Premium" means all money paid by covered insureds and covered individuals as
1245 a condition of receiving coverage from a covered carrier, including any fees or other
1246 contributions associated with the health benefit plan.
1247 (21) (a) "Rating period" means the calendar period for which premium rates
1248 established by a covered carrier are assumed to be in effect, as determined by the carrier.
1249 (b) A covered carrier may not have:
1250 (i) more than one rating period in any calendar month; and
1251 (ii) no more than 12 rating periods in any calendar year.
1252 (22) "Resident" means an individual who has resided in this state for at least 12
1253 consecutive months immediately preceding the date of application.
1254 (23) "Short-term limited duration insurance" means a health benefit product that:
1255 (a) is not renewable; and
1256 (b) has an expiration date specified in the contract that is less than 364 days after the
1257 date the plan became effective.
1258 (24) "Small employer carrier" means a carrier that provides health benefit plans
1259 covering eligible employees of one or more small employers in this state, regardless of
1260 whether:
1261 (a) coverage is offered through:
1262 (i) an association;
1263 (ii) a trust;
1264 (iii) a discretionary group; or
1265 (iv) other similar grouping; or

1266 (b) the policy or contract is situated out-of-state.
1267 (25) "Uninsurable" means an individual who:
1268 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
1269 underwriting criteria established in Subsection 31A-29-111(5); or
1270 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
1271 (ii) has a condition of health that does not meet consistently applied underwriting
1272 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)
1273 and (j) for which coverage the applicant is applying.
1274 (26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
1275 purposes of this formula:
1276 (a) "CI" means the carrier's individual coverage count as of December 31 of the
1277 preceding year; and
1278 (b) "UC" means the number of uninsurable individuals who were issued an individual
1279 policy on or after July 1, 1997.
1280 Section 17. Section **31A-30-104** is amended to read:
1281 **31A-30-104. Applicability and scope.**
1282 (1) This chapter applies to any:
1283 (a) health benefit plan that provides coverage to:
1284 (i) individuals;
1285 (ii) small employers; or
1286 (iii) both Subsections (1)(a)(i) and (ii); or
1287 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
1288 31A-30-107.5.
1289 (2) This chapter applies to a health benefit plan that provides coverage to small
1290 employers or individuals regardless of:
1291 (a) whether the contract is issued to:
1292 (i) an association;
1293 (ii) a trust;
1294 (iii) a discretionary group; or
1295 (iv) other similar grouping; or
1296 (b) the situs of delivery of the policy or contract.

1297 (3) This chapter does not apply to:
1298 [~~(a) a large employer health benefit plan, except as specifically provided in Part 2,~~
1299 ~~Defined Contribution Arrangements;~~]
1300 [~~(b)~~] (a) short-term limited duration health insurance; or
1301 [~~(c)~~] (b) federally funded or partially funded programs.
1302 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:
1303 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
1304 return shall be treated as one carrier; and
1305 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
1306 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
1307 carriers were issued by one carrier.
1308 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
1309 maintenance organization having a certificate of authority under this title may be considered to
1310 be a separate carrier for the purposes of this chapter.
1311 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
1312 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
1313 arrangements with respect to health benefit plans delivered or issued for delivery to covered
1314 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
1315 obligation or risk for the health benefit plans being retained by the ceding carrier.
1316 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
1317 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
1318 for delivery to covered insureds in this state.
1319 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
1320 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
1321 may make a written request to the commissioner for a waiver from the application of any of the
1322 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
1323 trust.
1324 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
1325 waiver if the commissioner finds that application with respect to the trust would:
1326 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
1327 and

1328 (ii) require significant modifications to one or more collective bargaining arrangements
1329 under which the trust is established or maintained.
1330 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
1331 person participates in a Taft Hartley trust as an associate member of any employee
1332 organization.
1333 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
1334 31A-30-111 apply to:
1335 (a) any insurer engaging in the business of insurance related to the risk of a small
1336 employer for medical, surgical, hospital, or ancillary health care expenses of the small
1337 employer's employees provided as an employee benefit; and
1338 (b) any contract of an insurer, other than a workers' compensation policy, related to the
1339 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
1340 small employer's employees provided as an employee benefit.
1341 (7) The commissioner may make rules requiring that the marketing practices be
1342 consistent with this chapter for:
1343 (a) a small employer carrier;
1344 (b) a small employer carrier's agent;
1345 (c) an insurance producer; and
1346 (d) an insurance consultant.
1347 Section 18. Section **31A-30-106.1** is amended to read:
1348 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**
1349 (1) Premium rates for small employer health benefit plans under this chapter are
1350 subject to the provisions of this section for a health benefit plan that is issued or renewed, on or
1351 after [~~January 1~~] July 1, 2011.
1352 (2) (a) The index rate for a rating period for any class of business may not exceed the
1353 index rate for any other class of business by more than 20%.
1354 (b) For a class of business, the premium rates charged during a rating period to covered
1355 insureds with similar case characteristics for the same or similar coverage, or the rates that
1356 could be charged to an employer group under the rating system for that class of business, may
1357 not vary from the index rate by more than 30% of the index rate, except when catastrophic
1358 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

1359 (3) The percentage increase in the premium rate charged to a covered insured for a new
1360 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
1361 the following:
1362 (a) the percentage change in the new business premium rate measured from the first
1363 day of the prior rating period to the first day of the new rating period;
1364 (b) any adjustment, not to exceed 15% annually for rating periods of less than one year,
1365 due to the claim experience, health status, or duration of coverage of the covered individuals as
1366 determined from the small employer carrier's rate manual for the class of business, except when
1367 catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d);
1368 and
1369 (c) any adjustment due to change in coverage or change in the case characteristics of
1370 the covered insured as determined for the class of business from the small employer carrier's
1371 rate manual.
1372 (4) (a) Adjustments in rates for claims experience, health status, and duration from
1373 issue may not be charged to individual employees or dependents.
1374 (b) Rating adjustments and factors, including case characteristics, shall be applied
1375 uniformly and consistently to the rates charged for all employees and dependents of the small
1376 employer.
1377 (c) Rating factors shall produce premiums for identical groups that:
1378 (i) differ only by the amounts attributable to plan design; and
1379 (ii) do not reflect differences due to the nature of the groups assumed to select
1380 particular health benefit products.
1381 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the
1382 same calendar month as having the same rating period.
1383 (5) A health benefit plan that uses a restricted network provision may not be considered
1384 similar coverage to a health benefit plan that does not use a restricted network provision,
1385 provided that use of the restricted network provision results in substantial difference in claims
1386 costs.
1387 (6) The small employer carrier may not use case characteristics other than the
1388 following:
1389 (a) age, as determined at the beginning of the plan year, limited to:

1390 (i) the following age bands:
1391 (A) less than 20;
1392 (B) 20-24;
1393 (C) 25-29;
1394 (D) 30-34;
1395 (E) 35-39;
1396 (F) 40-44;
1397 (G) 45-49;
1398 (H) 50-54;
1399 (I) 55-59;
1400 (J) 60-64; and
1401 (K) 65 and above; and
1402 (ii) a standard slope ratio range for each age band, applied to each family composition
1403 tier rating structure under Subsection (6)(c):
1404 (A) as developed by the department by administrative rule;
1405 (B) not to exceed an overall ratio of 5:1; and
1406 (C) the age slope ratios for each age band may not overlap;
1407 (b) geographic area; [~~and~~]
1408 (c) family composition, limited to:
1409 (i) an overall ratio of 5:1 or less; and
1410 (ii) a four tier rating structure that includes:
1411 (A) employee only;
1412 (B) employee plus spouse;
1413 (C) employee plus a dependent or dependents; and
1414 (D) a family, consisting of an employee plus spouse, and a dependent or dependents<u>;</u>
1415 <u>and</u>
1416 <u>(d) gender</u>.
1417 (7) If a health benefit plan is a health benefit plan into which the small employer carrier
1418 is no longer enrolling new covered insureds, the small employer carrier shall use the percentage
1419 change in the base premium rate, provided that the change does not exceed, on a percentage
1420 basis, the change in the new business premium rate for the most similar health benefit product

1421 into which the small employer carrier is actively enrolling new covered insureds.
1422 (8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
1423 a class of business.
1424 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
1425 of business unless the offer is made to transfer all covered insureds in the class of business
1426 without regard to:
1427 (i) case characteristics;
1428 (ii) claim experience;
1429 (iii) health status; or
1430 (iv) duration of coverage since issue.
1431 (9) (a) Each small employer carrier shall maintain at the small employer carrier's
1432 principal place of business a complete and detailed description of its rating practices and
1433 renewal underwriting practices, including information and documentation that demonstrate that
1434 the small employer carrier's rating methods and practices are:
1435 (i) based upon commonly accepted actuarial assumptions; and
1436 (ii) in accordance with sound actuarial principles.
1437 (b) (i) Each small employer carrier shall file with the commissioner on or before April
1438 1 of each year, in a form and manner and containing information as prescribed by the
1439 commissioner, an actuarial certification certifying that:
1440 (A) the small employer carrier is in compliance with this chapter; and
1441 (B) the rating methods of the small employer carrier are actuarially sound.
1442 (ii) A copy of the certification required by Subsection (9)(b)(i) shall be retained by the
1443 small employer carrier at the small employer carrier's principal place of business.
1444 (c) A small employer carrier shall make the information and documentation described
1445 in this Subsection (9) available to the commissioner upon request.
1446 (10) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with
1447 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:
1448 (i) implement this chapter; and
1449 (ii) assure that rating practices used by small employer carriers under this section and
1450 carriers for individual plans under Section 31A-30-106, as effective on January 1, 2011, are
1451 consistent with the purposes of this chapter.

1452 (b) The rules may:
1453 (i) assure that differences in rates charged for health benefit plans by carriers are
1454 reasonable and reflect objective differences in plan design, not including differences due to the
1455 nature of the groups or individuals assumed to select particular health benefit plans; and
1456 (ii) prescribe the manner in which case characteristics may be used by small employer
1457 and individual carriers.
1458 (11) Records submitted to the commissioner under this section shall be maintained by
1459 the commissioner as protected records under Title 63G, Chapter 2, Government Records
1460 Access and Management Act.
1461 Section 19. Section **31A-30-115** is enacted to read:
1462 **31A-30-115. Actuarial review of health benefit plans.**
1463 (1) (a) The department shall conduct an actuarial review of rates submitted by small
1464 employer carriers:
1465 (i) prior to the publication of the premium rates on the Health Insurance Exchange;
1466 (ii) to determine if the rates are in compliance with Subsection 31A-30-202.5(1)(b);
1467 (iii) to verify the validity of the rates, underwriting and risk factors, and premiums of
1468 plans both in and outside of the Health Insurance Exchange;
1469 (iv) to verify that insurers are pricing similar health benefit plans and groups the same
1470 in and out of the exchange; and
1471 (v) as the department determines is necessary to oversee market conduct.
1472 (b) The actuarial review by the department shall be funded from a fee:
1473 (i) established by the department in accordance with Section 63J-1-504; and
1474 (ii) paid by all small employer carriers participating in the defined contribution
1475 arrangement market and small employer carriers offering health benefit plans under Chapter
1476 30, Part 1, Individual and Small Employer Group.
1477 (c) The department shall:
1478 (i) report aggregate data from the actuarial review to the risk adjuster board created in
1479 Section 31A-42-201; and
1480 (ii) contact carriers, if the department determines it is appropriate, to:
1481 (A) inform a carrier of the department's findings regarding the rates of a particular
1482 carrier; and

1483 (B) request a carrier to recalculate or verify base rates, rating factors, and premiums.
1484 (d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).
1485 (2) (a) There is created in the General Fund a restricted account known as the "Health
1486 Insurance Actuarial Review Restricted Account."
1487 (b) The Health Insurance Actuarial Review Restricted Account shall consist of money
1488 received by the commissioner under this section.
1489 (c) The commissioner shall administer the Health Insurance Actuarial Review
1490 Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use
1491 money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the
1492 actuarial review conducted by the department under this section.
1493 Section 20. Section **31A-30-203** is amended to read:
1494 **31A-30-203. Eligibility for defined contribution arrangement market --**
1495 **Enrollment.**
1496 (1) (a) An eligible small employer may choose to participate in:
1497 (i) the defined contribution arrangement market in the Health Insurance Exchange
1498 under this part; or
1499 (ii) the traditional defined benefit market under Part 1, Individual and Small Employer
1500 Group.
1501 (b) A small employer may choose to offer its employees one of the following through
1502 the defined contribution arrangement market in the Health Insurance Exchange:
1503 (i) a defined contribution arrangement health benefit plan; or
1504 (ii) a defined benefit plan.
1505 [~~(c) (i) Beginning January 1, 2011, and during the enrollment period, an eligible large~~
1506 ~~employer participating in the demonstration project under Subsection 31A-30-208(1)(c) may~~
1507 ~~choose to offer its employees a defined contribution arrangement health benefit plan.~~]
1508 [~~(ii) Beginning January 1, 2012, an eligible large employer may choose to offer its~~
1509 ~~employees a defined contribution arrangement health benefit plan.~~]
1510 [~~(d)~~] (c) Defined contribution arrangement health benefit plans are employer group
1511 health plans individually selected by an employee of an employer.
1512 (2) (a) Participating insurers shall offer to accept all eligible employees of an employer
1513 described in Subsection (1), and their dependents, at the same level of benefits as anyone else

1514 who has the same health benefit plan in the defined contribution arrangement market on the
1515 Health Insurance Exchange.
1516 (b) A participating insurer may:
1517 (i) request an employer to submit a copy of the employer's quarterly wage list to
1518 determine whether the employees for whom coverage is provided or requested are bona fide
1519 employees of the employer; and
1520 (ii) deny or terminate coverage if the employer refuses to provide documentation
1521 requested under Subsection (2)(b)(i).
1522 Section 21. Section **31A-30-205** is amended to read:
1523 **31A-30-205. Health benefit plans offered in the defined contribution market.**
1524 (1) An insurer who offers a defined contribution arrangement health benefit plan in the
1525 small group market shall offer the following health benefit plans as defined contribution
1526 arrangements:
1527 [~~(a) the basic benefit plan;~~]
1528 (a) one health benefit plan that:
1529 (i) is a federally qualified high deductible health plan;
1530 (ii) has a deductible that is within $250 of the lowest deductible that qualifies as a
1531 federally qualified high deductible health plan as adjusted by federal law; and
1532 (iii) has an annual out-of-pocket maximum that does not exceed three times the amount
1533 of the deductible;
1534 [~~(b) one health benefit plan with an aggregate actuarial value at least 15% greater than~~
1535 ~~the actuarial value of the basic benefit plan;~~]
1536 [~~(c)~~] (b) [~~on or before January 1, 2011,~~] one health benefit plan that:
1537 (i) is a federally qualified high deductible health plan that [~~has~~] is within $250 of an
1538 individual deductible of $2,500 and a deductible of $5,000 for coverage including two or more
1539 individuals[~~,~~]; and
1540 (ii) does not exceed an annual out-of-pocket maximum equal to three times the amount
1541 of the annual deductible;
1542 [~~(d) on or before January 1, 2011,~~]
1543 (c) one health benefit plan that:
1544 (i) is a federally qualified high deductible health plan [~~that~~];

1545 (ii) has a deductible that is within [~~$250~~] $1,000 of the highest deductible that qualifies
1546 as a federally qualified high deductible health plan, as adjusted by federal law[~~, and does not~~
1547 ~~exceed an annual out-of-pocket maximum equal to three times the amount of the annual~~
1548 ~~deductible~~]; and
1549 (iii) has an out-of-pocket maximum that qualifies as a federally qualified high
1550 deductible health plan;
1551 [~~(c)~~] (d) the insurer's [~~five~~] four most commonly selected small group health benefit
1552 plans that:
1553 (i) include:
1554 (A) the provider panel;
1555 (B) the deductible;
1556 (C) co-payments;
1557 (D) co-insurance; and
1558 (E) pharmacy benefits; [~~and~~]
1559 (ii) are currently being marketed by the carrier to new groups for enrollment[~~.~~]; and
1560 (iii) meet the standard for most commonly selected plan as determined by
1561 administrative rule adopted by the commissioner; and
1562 (e) alternative coverage required by Section 31A-22-724.
1563 (2) (a) The provisions of Subsection (1) do not limit the number of defined
1564 contribution arrangement health benefit plans an insurer may offer in the defined contribution
1565 arrangement market.
1566 (b) An insurer who offers the health benefit plans required by Subsection (1) may also
1567 offer any other health benefit plan as a defined contribution arrangement if[~~: (i) the health~~
1568 ~~benefit plan provides benefits that are of greater actuarial value than the benefits required in the~~
1569 ~~basic benefit plan; or (ii)~~] the health benefit plan provides benefits with an aggregate actuarial
1570 value that is no lower than the actuarial value of the plan required in Subsection (1)(c).
1571 (3) An employee who has the right to extend employer coverage under Subsection
1572 31A-22-722(1) or federal COBRA, may:
1573 (a) continue coverage under the employee's current plan under state mini-COBRA or
1574 federal COBRA; or
1575 (b) enroll in alternative coverage under Section 31A-22-724.

1576 Section 22. Section **31A-30-207** is amended to read:

1577 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**
1578 **contribution arrangement market.**

1579 (1) The rating and underwriting restrictions for defined benefit plans and for the
1580 defined contribution arrangement health benefit plans offered in the Health Insurance
1581 Exchange defined contribution arrangement market shall be[~~: (a) for small employer groups,~~]
1582 in accordance with Section 31A-30-106.1[~~; (b) for large employer groups, as determined by~~
1583 ~~the risk adjuster board for participation in the risk adjustment mechanism under Chapter 42,~~
1584 ~~Defined Contribution Risk Adjuster Act; and (c) established in accordance with~~], and the plan
1585 adopted under Chapter 42, Defined Contribution Risk Adjuster Act.

1586 (2) All insurers who participate in the defined contribution market shall:

1587 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined
1588 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

1589 (b) provide the risk adjuster board with:

1590 (i) an employer group's risk factor; and

1591 (ii) carrier enrollment data; and

1592 (c) submit rates to the exchange that are net of commissions.

1593 (3) When an employer group [~~of any size~~] enters the defined contribution arrangement
1594 market for either a defined contribution arrangement health benefit plan, or a defined benefit
1595 plan, and the employer group has a health plan with an insurer who is participating in the
1596 defined contribution arrangement market, the risk factor applied to the employer group when it
1597 enters the defined contribution market may not be greater than the employer group's renewal
1598 risk factor for the same group of covered employees and the same effective date, as determined
1599 by the employer group's insurer.

1600 Section 23. Section **31A-30-208** is amended to read:

1601 **31A-30-208. Enrollment for defined contribution arrangements.**

1602 (1) An insurer offering a health benefit plan in the defined contribution arrangement
1603 market:

1604 (a) [~~beginning on or after January 1, 2011,~~] shall allow an employer to enroll in a small
1605 employer defined contribution arrangement plan;

1606 (b) may not impose a surcharge under Section 31A-30-106.7 for a small employer

1607 group selecting a defined contribution arrangement health benefit plan on or before January 1,
1608 2012; and
1609 [(c) shall offer a limited pilot program in which a large employer group may enroll in a
1610 defined contribution arrangement market plan that takes effect January 1, 2011;]
1611 [(d) beginning January 1, 2012, shall allow a large employer group to enroll in the
1612 defined contribution arrangement market; and]
1613 [(e)] (c) shall otherwise comply with the requirements of this part, Chapter 42, Defined
1614 Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.
1615 (2) (a) Except as provided in Subsection 31A-30-202.5(2), in accordance with
1616 Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined
1617 contribution arrangement market.
1618 (b) An insurer may offer new or modify existing products in the defined contribution
1619 arrangement market:
1620 (i) on January 1 of each year;
1621 (ii) when required by changes in other law; and
1622 (iii) at other times as established by the risk adjuster board created in Section
1623 31A-42-201.
1624 (c) (i) An insurer shall give the department, the Health Insurance Exchange, and the
1625 risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a)
1626 or (b).
1627 (ii) When an insurer elects to participate in the defined contribution arrangement
1628 market, the insurer shall participate in the defined contribution arrangement market for no less
1629 than two years.
1630 Section 24. Section **31A-30-209** is amended to read:
1631 **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**
1632 (1) A producer may be listed on the Health Insurance Exchange as a producer for the
1633 defined contribution arrangement market in accordance with Section 63M-1-2504, if the
1634 producer is designated as an appointed agent for the defined contribution arrangement market
1635 in accordance with Subsection (2).
1636 (2) A producer whose license under this title authorizes the producer to sell defined
1637 contribution arrangement health benefit plans may be appointed to the defined contribution

1638 arrangement market on the Health Insurance Exchange by the Insurance Department and may
1639 sell any product on the Health Insurance Exchange, if the producer:
1640 (a) submits an application to the Insurance Department to be appointed as a producer
1641 for the defined contribution arrangement market on the Health Insurance Exchange;
1642 (b) is an appointed agent in accordance with Subsection (3), for products offered in the
1643 defined contribution arrangement market of the Health Insurance Exchange, with the [majority
1644 of the] carriers that offer a defined contribution arrangement health benefit plan on the Health
1645 Insurance Exchange; and
1646 (c) has completed [a] continuing education for the defined contribution arrangement
1647 [training session that is an approved training session as designated by the commissioner.]
1648 market that:
1649 (i) is required by administrative rule adopted by the commissioner; and
1650 (ii) provides training on premium assistance programs.
1651 (3) A carrier shall appoint a producer to sell the carrier's products in the defined
1652 contribution arrangement market of the Health Insurance Exchange, within 30 days of the
1653 notice required in Subsection (3)(b), if:
1654 (a) the producer is currently appointed by a majority of the carriers in the Health
1655 Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange;
1656 and
1657 (b) the producer informs the carrier that the producer is:
1658 (i) applying to be appointed to the defined contribution arrangement market in the
1659 Health Insurance Exchange;
1660 (ii) appointed by a majority of the carriers in the defined contribution arrangement
1661 market in the Health Insurance Exchange;
1662 (iii) willing to complete training regarding the carrier's products offered on the defined
1663 contribution arrangement market in the Health Insurance Exchange; and
1664 (iv) willing to sign the contracts and business associate's agreements that the carrier
1665 requires for appointed producers in the Health Insurance Exchange.
1666 Section 25. Section **31A-30-211** is enacted to read:
1667 **31A-30-211. Insurer disclosure.**
1668 (1) The Health Insurance Exchange shall provide an employer and an employer's

1669 producer with the group's risk factor used to calculate the employer group's premium at the
1670 time of:
1671 (a) the initial offering of a health benefit plan; and
1672 (b) the renewal of a health benefit plan.
1673 (2) For health benefit plans that renew on or after March 1, 2012:
1674 (a) a carrier in the small employer market under Part 1, Individual and Small Employer
1675 Group, shall provide an employer and the employer's producer with premium renewal rates at
1676 least 90 days prior to the group's renewal date; and
1677 (b) the Health Insurance Exchange shall provide an employer who is participating in
1678 the defined contribution arrangement market of the Health Insurance Exchange and the
1679 employer's producer with premium renewal rates at least 90 days prior to a group's renewal.
1680 Section 26. Section **31A-42-202** is amended to read:
1681 **31A-42-202. Contents of plan.**
1682 (1) The board shall submit a plan of operation for the risk adjuster to the
1683 commissioner. The plan shall:
1684 (a) establish the methodology for implementing:
1685 (i) Subsection (2) for the defined contribution arrangement market established under
1686 Chapter 30, Part 2, Defined Contribution Arrangements; and
1687 (ii) the participation of[~~: (A)~~] small employer group defined contribution arrangement
1688 health benefit plans; [~~and~~]
1689 [~~(B) large employer group defined contribution arrangement health benefit plans;~~]
1690 (b) establish regular times and places for meetings of the board;
1691 (c) establish procedures for keeping records of all financial transactions and for
1692 sending annual fiscal reports to the commissioner;
1693 (d) contain additional provisions necessary and proper for the execution of the powers
1694 and duties of the risk adjuster; and
1695 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
1696 Code, to pay for administrative expenses incurred.
1697 (2) (a) The plan adopted by the board for the defined contribution arrangement market
1698 shall include:
1699 (i) parameters an employer may use to designate eligible employees for the defined

1700 contribution arrangement market; and
1701 (ii) underwriting mechanisms and employer eligibility guidelines:
1702 (A) consistent with the federal Health Insurance Portability and Accountability Act;
1703 and
1704 (B) necessary to protect insurance carriers from adverse selection in the defined
1705 contribution market.
1706 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
1707 qualified individual are determined, including:
1708 (i) the identification of an initial rate for a qualified individual based on:
1709 (A) standardized age bands submitted by participating insurers; and
1710 (B) wellness incentives for the individual as permitted by federal law; and
1711 (ii) the identification of a group risk factor to be applied to the initial age rate of a
1712 qualified individual based on the health conditions of all qualified individuals in the same
1713 employer group and, for small employers, in accordance with Sections 31A-30-105 and
1714 31A-30-106.1.
1715 (c) The plan adopted under Subsection (2)(a) shall outline how:
1716 (i) premium contributions for qualified individuals shall be submitted to the Health
1717 Insurance Exchange in the amount determined under Subsection (2)(b); and
1718 (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by
1719 qualified individuals within an employer group based on each individual's rating factor
1720 determined in accordance with the plan.
1721 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
1722 risk between insurers that:
1723 (i) identifies health care conditions subject to risk adjustment;
1724 (ii) establishes an adjustment amount for each identified health care condition;
1725 (iii) determines the extent to which an insurer has more or less individuals with an
1726 identified health condition than would be expected; and
1727 (iv) computes all risk adjustments.
1728 (e) The board may amend the plan if necessary to:
1729 [~~(i) incorporate large group defined contribution arrangement health benefit plans into~~
1730 ~~the defined contribution arrangement market risk adjuster mechanism created by this chapter;~~]

1731 [(ii)] (i) maintain the proper functioning and solvency of the defined contribution
1732 arrangement market and the risk adjuster mechanism;
1733 [(iii)] (ii) mitigate significant issues of risk selection; or
1734 [(iv)] (iii) improve the administration of the risk adjuster mechanism [including
1735 opening enrollment periodically until January 1, 2011, for the purpose of testing the enrollment
1736 and risk adjusting process].
1737 (3) [(a)] The board shall establish a mechanism in which the participating carriers shall
1738 submit their plan base rates, rating factors, and premiums to [an independent actuary, appointed
1739 by the board, for review prior to the publication of the premium rates on the Health Insurance
1740 Exchange] the commissioner for an actuarial review under the provisions of Section
1741 31A-30-115 prior to the publication of the premium rates on the Health Insurance Exchange.
1742 [(b) The actuary appointed by the board shall:]
1743 [(i) be compensated for the analysis under this section from fees established in
1744 accordance with Section 63J-1-504:]
1745 [(A) assessed by the board; and]
1746 [(B) paid by all small employer carriers participating in the defined contribution
1747 arrangement market and small employer carriers offering health benefit plans under Chapter
1748 30, Part 1, Individual and Small Employer Group; and]
1749 [(ii) review the information submitted:]
1750 [(A) under Subsection (3)(a) for the purpose of verifying the validity of the rates, rating
1751 factors, and premiums; and]
1752 [(B) from carriers offering health benefit plans under Chapter 30, Part 1, Individual and
1753 Small Employer Group:]
1754 [(I) for the purpose of verifying underwriting and rating practices; and]
1755 [(II) as the actuary determines is necessary.]
1756 [(c) Fees collected under Subsection (3)(b) shall be used to pay the actuary for the
1757 purpose of overseeing market conduct.]
1758 [(d) The actuary shall:]
1759 [(i) report aggregate data to the risk adjuster board;]
1760 [(ii) contact carriers:]
1761 [(A) to inform a carrier of the actuary's findings regarding the particular carrier; and]

1762 [~~(B) to request a carrier to re-calculate or verify base rates, rating factors, and~~
1763 ~~premiums; and~~]
1764 [~~(iii) share the actuary's analysis and data with the department for the purposes~~
1765 ~~described in Section 31A-30-106.1.~~]
1766 [~~(c) A carrier shall re-submit premium rates if the department contacts the carrier under~~
1767 ~~Subsection (3).~~]
1768 Section 27. Section **63A-5-205** is amended to read:
1769 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**
1770 **coverage.**
1771 (1) As used in this section:
1772 (a) "Capital developments" has the same meaning as provided in Section 63A-5-104.
1773 (b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.
1774 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section
1775 34A-2-104 who:
1776 (i) works at least 30 hours per calendar week; and
1777 (ii) meets employer eligibility waiting requirements for health care insurance which
1778 may not exceed the first day of the calendar month following 90 days from the date of hire.
1779 (d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
1780 (e) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
1781 ~~or renewed:~~] is as defined in Section 26-40-115.
1782 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
1783 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
1784 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
1785 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
1786 ~~employee who reside or work in the state, in which:~~]
1787 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
1788 ~~dependents of the employee who reside or work in the state; and~~]
1789 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(e)(i):~~]
1790 [~~(I) rather that the benchmark plan's deductible, and the benchmark plan's~~
1791 ~~out-of-pocket maximum based on income levels:~~]
1792 [~~(Aa) the deductible is $750 per individual and $2,250 per family; and~~]

1793 [~~(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;~~]
1794 [~~(II) dental coverage is not required; and~~]
1795 [~~(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
1796 ~~not apply; or~~]
1797 [~~(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
1798 ~~deductible that is either:~~]
1799 [~~(I) the lowest deductible permitted for a federally qualified high deductible health~~
1800 ~~plan; or~~]
1801 [~~(II) a deductible that is higher than the lowest deductible permitted for a federally~~
1802 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
1803 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
1804 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
1805 ~~employer offered federally qualified high deductible plan;~~]
1806 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
1807 ~~annual deductible; and~~]
1808 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
1809 ~~dependents of the employee who work or reside in the state.~~]
1810 (f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
1811 (2) In accordance with Title 63G, Chapter 6, Utah Procurement Code, the director may:
1812 (a) subject to Subsection (3), enter into contracts for any work or professional services
1813 which the division or the State Building Board may do or have done; and
1814 (b) as a condition of any contract for architectural or engineering services, prohibit the
1815 architect or engineer from retaining a sales or agent engineer for the necessary design work.
1816 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design
1817 or construction contracts entered into by the division or the State Building Board on or after
1818 July 1, 2009, and:
1819 (i) applies to a prime contractor if the prime contract is in the amount of $1,500,000 or
1820 greater; and
1821 (ii) applies to a subcontractor if the subcontract is in the amount of $750,000 or greater.
1822 (b) This Subsection (3) does not apply:
1823 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

1824 (ii) if the contract is a sole source contract;
1825 (iii) if the contract is an emergency procurement; or
1826 (iv) to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification
1827 to a contract, when the contract does not meet the threshold required by Subsection (3)(a).
1828 (c) A person who intentionally uses change orders or contract modifications to
1829 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.
1830 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that
1831 the contractor has and will maintain an offer of qualified health insurance coverage for the
1832 contractor's employees and the employees' dependents.
1833 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor
1834 shall demonstrate to the director that the subcontractor has and will maintain an offer of
1835 qualified health insurance coverage for the subcontractor's employees and the employees'
1836 dependents.
1837 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)
1838 during the duration of the contract is subject to penalties in accordance with administrative
1839 rules adopted by the division under Subsection (3)(f).
1840 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1841 requirements of Subsection (3)(d)(ii).
1842 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)
1843 during the duration of the contract is subject to penalties in accordance with administrative
1844 rules adopted by the division under Subsection (3)(f).
1845 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1846 requirements of Subsection (3)(d)(i).
1847 (f) The division shall adopt administrative rules:
1848 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
1849 (ii) in coordination with:
1850 (A) the Department of Environmental Quality in accordance with Section 19-1-206;
1851 (B) the Department of Natural Resources in accordance with Section 79-2-404;
1852 (C) a public transit district in accordance with Section 17B-2a-818.5;
1853 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;
1854 (E) the Department of Transportation in accordance with Section 72-6-107.5; and

1855 (F) the Legislature's Administrative Rules Review Committee; and
1856 (iii) which establish:
1857 (A) the requirements and procedures a contractor must follow to demonstrate to the
1858 director compliance with this Subsection (3) which shall include:
1859 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)
1860 or (ii) more than twice in any 12-month period; and
1861 (II) that the actuarially equivalent determination required for the qualified health
1862 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
1863 department or division with a written statement of actuarial equivalency from either:
1864 (Aa) the Utah Insurance Department;
1865 (Bb) an actuary selected by the contractor or the contractor's insurer; or
1866 (Cc) an underwriter who is responsible for developing the employer group's premium
1867 rates;
1868 (B) the penalties that may be imposed if a contractor or subcontractor intentionally
1869 violates the provisions of this Subsection (3), which may include:
1870 (I) a three-month suspension of the contractor or subcontractor from entering into
1871 future contracts with the state upon the first violation;
1872 (II) a six-month suspension of the contractor or subcontractor from entering into future
1873 contracts with the state upon the second violation;
1874 (III) an action for debarment of the contractor or subcontractor in accordance with
1875 Section 63G-6-804 upon the third or subsequent violation; and
1876 (IV) monetary penalties which may not exceed 50% of the amount necessary to
1877 purchase qualified health insurance coverage for an employee and the dependents of an
1878 employee of the contractor or subcontractor who was not offered qualified health insurance
1879 coverage during the duration of the contract; and
1880 (C) a website on which the department shall post the benchmark for the qualified
1881 health insurance coverage identified in Subsection (1)(e)[~~(i)~~].
1882 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or
1883 subcontractor who intentionally violates the provisions of this section shall be liable to the
1884 employee for health care costs that would have been covered by qualified health insurance
1885 coverage.

1886 (ii) An employer has an affirmative defense to a cause of action under Subsection
1887 (3)(g)(i) if:
1888 (A) the employer relied in good faith on a written statement of actuarial equivalency
1889 provided by:
1890 (I) an actuary; or
1891 (II) an underwriter who is responsible for developing the employer group's premium
1892 rates; or
1893 (B) the department determines that compliance with this section is not required under
1894 the provisions of Subsection (3)(b).
1895 (iii) An employee has a private right of action only against the employee's employer to
1896 enforce the provisions of this Subsection (3)(g).
1897 (h) Any penalties imposed and collected under this section shall be deposited into the
1898 Medicaid Restricted Account created by Section 26-18-402.
1899 (i) The failure of a contractor or subcontractor to provide qualified health insurance
1900 coverage as required by this section:
1901 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,
1902 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
1903 Legal and Contractual Remedies; and
1904 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or
1905 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
1906 or construction.
1907 (4) The judgment of the director as to the responsibility and qualifications of a bidder
1908 is conclusive, except in case of fraud or bad faith.
1909 (5) The division shall make all payments to the contractor for completed work in
1910 accordance with the contract and pay the interest specified in the contract on any payments that
1911 are late.
1912 (6) If any payment on a contract with a private contractor to do work for the division or
1913 the State Building Board is retained or withheld, it shall be retained or withheld and released as
1914 provided in Section 13-8-5.
1915 Section 28. Section **63C-9-403** is amended to read:
1916 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

1917 (1) For purposes of this section:
1918 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
1919 34A-2-104 who:
1920 (i) works at least 30 hours per calendar week; and
1921 (ii) meets employer eligibility waiting requirements for health care insurance which
1922 may not exceed the first of the calendar month following 90 days from the date of hire.
1923 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
1924 (c) "Qualified health insurance coverage" [means at the time the contract is entered into
1925 or renewed:] is as defined in Section 26-40-115.
1926 [(i) a health benefit plan and employer contribution level with a combined actuarial
1927 value at least actuarially equivalent to the combined actuarial value of the benchmark plan
1928 determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and
1929 a contribution level of 50% of the premium for the employee and the dependents of the
1930 employee who reside or work in the state, in which:]
1931 [(A) the employer pays at least 50% of the premium for the employee and the
1932 dependents of the employee who reside or work in the state; and]
1933 [(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]
1934 [(I) rather that the benchmark plan's deductible, and the benchmark plan's
1935 out-of-pocket maximum based on income levels:]
1936 [(Aa) the deductible is $750 per individual and $2,250 per family; and]
1937 [(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;]
1938 [(II) dental coverage is not required; and]
1939 [(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do
1940 not apply; or]
1941 [(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a
1942 deductible that is either:]
1943 [(I) the lowest deductible permitted for a federally qualified high deductible health
1944 plan; or]
1945 [(II) a deductible that is higher than the lowest deductible permitted for a federally
1946 qualified high deductible health plan, but includes an employer contribution to a health savings
1947 account in a dollar amount at least equal to the dollar amount difference between the lowest

1948 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
1949 ~~employer offered federally qualified high deductible plan;~~]
1950 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
1951 ~~annual deductible; and~~]
1952 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
1953 ~~dependents of the employee who work or reside in the state.~~]
1954 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
1955 (2) (a) Except as provided in Subsection (3), this section applies to a design or
1956 construction contract entered into by the board or on behalf of the board on or after July 1,
1957 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).
1958 (b) (i) A prime contractor is subject to this section if the prime contract is in the
1959 amount of $1,500,000 or greater.
1960 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
1961 $750,000 or greater.
1962 (3) This section does not apply if:
1963 (a) the application of this section jeopardizes the receipt of federal funds;
1964 (b) the contract is a sole source contract; or
1965 (c) the contract is an emergency procurement.
1966 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]
1967 63G-6-103, or a modification to a contract, when the contract does not meet the initial
1968 threshold required by Subsection (2).
1969 (b) A person who intentionally uses change orders or contract modifications to
1970 circumvent the requirements of Subsection (2) is guilty of an infraction.
1971 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
1972 director that the contractor has and will maintain an offer of qualified health insurance
1973 coverage for the contractor's employees and the employees' dependents during the duration of
1974 the contract.
1975 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
1976 shall demonstrate to the executive director that the subcontractor has and will maintain an offer
1977 of qualified health insurance coverage for the subcontractor's employees and the employees'
1978 dependents during the duration of the contract.

1979 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
1980 the duration of the contract is subject to penalties in accordance with administrative rules
1981 adopted by the division under Subsection (6).
1982 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1983 requirements of Subsection (5)(b).
1984 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
1985 the duration of the contract is subject to penalties in accordance with administrative rules
1986 adopted by the department under Subsection (6).
1987 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1988 requirements of Subsection (5)(a).
1989 (6) The department shall adopt administrative rules:
1990 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
1991 (b) in coordination with:
1992 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
1993 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
1994 (iii) the State Building Board in accordance with Section 63A-5-205;
1995 (iv) a public transit district in accordance with Section 17B-2a-818.5;
1996 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
1997 (vi) the Legislature's Administrative Rules Review Committee; and
1998 (c) which establish:
1999 (i) the requirements and procedures a contractor must follow to demonstrate to the
2000 executive director compliance with this section which shall include:
2001 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2002 (b) more than twice in any 12-month period; and
2003 (B) that the actuarially equivalent determination required <u>for the qualified health</u>
2004 <u>insurance coverage</u> in Subsection (1) is met by the contractor if the contractor provides the
2005 department or division with a written statement of actuarial equivalency from either:
2006 (I) the Utah Insurance Department;
2007 (II) an actuary selected by the contractor or the contractor's insurer; or
2008 (III) an underwriter who is responsible for developing the employer group's premium
2009 rates;

2010 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2011 violates the provisions of this section, which may include:
2012 (A) a three-month suspension of the contractor or subcontractor from entering into
2013 future contracts with the state upon the first violation;
2014 (B) a six-month suspension of the contractor or subcontractor from entering into future
2015 contracts with the state upon the second violation;
2016 (C) an action for debarment of the contractor or subcontractor in accordance with
2017 Section 63G-6-804 upon the third or subsequent violation; and
2018 (D) monetary penalties which may not exceed 50% of the amount necessary to
2019 purchase qualified health insurance coverage for employees and dependents of employees of
2020 the contractor or subcontractor who were not offered qualified health insurance coverage
2021 during the duration of the contract; and
2022 (iii) a website on which the department shall post the benchmark for the qualified
2023 health insurance coverage identified in Subsection (1)(c)[(i)].
2024 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
2025 subcontractor who intentionally violates the provisions of this section shall be liable to the
2026 employee for health care costs that would have been covered by qualified health insurance
2027 coverage.
2028 (ii) An employer has an affirmative defense to a cause of action under Subsection
2029 (7)(a)(i) if:
2030 (A) the employer relied in good faith on a written statement of actuarial equivalency
2031 provided by:
2032 (I) an actuary; or
2033 (II) an underwriter who is responsible for developing the employer group's premium
2034 rates; or
2035 (B) the department determines that compliance with this section is not required under
2036 the provisions of Subsection (3) or (4).
2037 (b) An employee has a private right of action only against the employee's employer to
2038 enforce the provisions of this Subsection (7).
2039 (8) Any penalties imposed and collected under this section shall be deposited into the
2040 Medicaid Restricted Account created in Section 26-18-402.

2041 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2042 coverage as required by this section:
2043 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2044 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2045 Legal and Contractual Remedies; and
2046 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2047 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2048 or construction.
2049 Section 29. Section **63I-1-231** is amended to read:
2050 **63I-1-231. Repeal dates, Title 31A.**
2051 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.
2052 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.
2053 (3) Section 31A-22-625, Catastrophic coverage of mental health conditions, is repealed
2054 July 1, 2011.
2055 [~~(4) Chapter 42a, Utah Statewide Risk Adjuster Act, is repealed July 1, 2016.~~]
2056 Section 30. Section **63J-1-602.2** is amended to read:
2057 **63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.**
2058 (1) Appropriations from the Technology Development Restricted Account created in
2059 Section 31A-3-104.
2060 (2) Appropriations from the Criminal Background Check Restricted Account created in
2061 Section 31A-3-105.
2062 (3) Appropriations from the Captive Insurance Restricted Account created in Section
2063 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that
2064 section free revenue.
2065 (4) Appropriations from the Title Licensee Enforcement Restricted Account created in
2066 Section 31A-23a-415.
2067 (5) The fund for operating the state's Federal Health Care Tax Credit Program, as
2068 provided in Section 31A-38-104.
2069 (6) Appropriations from the Health Insurance Actuarial Review Restricted Account
2070 created in Section 31A-30-115.
2071 [~~(6)~~] (7) The Special Administrative Expense Account created in Section 35A-4-506.

2072 [~~(7)~~] (8) Funding for a new program or agency that is designated as nonlapsing under
2073 Section 36-24-101.
2074 [~~(8)~~] (9) The Oil and Gas Conservation Account created in Section 40-6-14.5.
2075 [~~(9)~~] (10) The Off-Highway Access and Education Restricted Account created in
2076 Section 41-22-19.5.
2077 Section 31. Section **63M-1-2504** is amended to read:
2078 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
2079 (1) There is created within the Governor's Office of Economic Development the Office
2080 of Consumer Health Services.
2081 (2) The office shall:
2082 (a) in cooperation with the Insurance Department, the Department of Health, and the
2083 Department of Workforce Services, and in accordance with the electronic standards developed
2084 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:
2085 [~~(i) is capable of providing access to private and government health insurance websites~~
2086 ~~and their electronic application forms and submission procedures;~~]
2087 (i) provides information to consumers about private and public health programs for
2088 which the consumer may qualify;
2089 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
2090 on the Health Insurance Exchange [~~by an insurer for the:~~]; and
2091 [~~(A) small employer group market;~~]
2092 [~~(B) the individual market; and~~]
2093 [~~(C) the defined contribution arrangement market; and~~]
2094 (iii) includes information and a link to enrollment in premium assistance programs and
2095 other government assistance programs;
2096 (b) [~~facilitate a private sector method~~] contract with one or more private vendors for:
2097 (i) administration of the enrollment process on the Health Insurance Exchange,
2098 including establishing a mechanism for consumers to compare health benefit plan features on
2099 the exchange and filter the plans based on consumer preferences;
2100 (ii) the collection of health insurance premium payments made for a single policy by
2101 multiple payers, including the policyholder, one or more employers of one or more individuals
2102 covered by the policy, government programs, and others [~~by educating employers and insurers~~

2103 about collection services available through private vendors, including financial institutions];
2104 and
2105 (iii) establishing a call center in accordance with Subsection (3);
2106 (c) assist employers with a free or low cost method for establishing mechanisms for the
2107 purchase of health insurance by employees using pre-tax dollars;
2108 [(d) periodically convene health care providers, payers, and consumers to monitor the
2109 progress being made regarding demonstration projects for health care delivery and payment
2110 reform;]
2111 [(e)] (d) establish a list on the Health Insurance Exchange of insurance producers who,
2112 in accordance with Section 31A-30-209, are appointed producers for the [defined contribution
2113 arrangement market on the] Health Insurance Exchange; and
2114 [(f)] (e) report to the Business and Labor Interim Committee and the Health System
2115 Reform Task Force prior to November 1, [2010] 2011, and prior to the Legislative interim day
2116 in November of each year thereafter regarding[: (i)] the operations of the Health Insurance
2117 Exchange required by this chapter[; and].
2118 [(ii) the progress of the demonstration projects for health care payment and delivery
2119 reform.]
2120 (3) A call center established by the office:
2121 (a) shall provide unbiased answers to questions concerning exchange operations, and
2122 plan information, to the extent the plan information is posted on the exchange by the insurer;
2123 and
2124 (b) may not:
2125 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;
2126 (ii) beginning July 1, 2011, receive producer compensation through the Health
2127 Insurance Exchange; and
2128 (iii) beginning July 1, 2011, be designated as the default producer for an employer
2129 group that enters the Health Insurance Exchange without a producer.
2130 [(3)] (4) The office:
2131 (a) may not:
2132 (i) regulate health insurers, health insurance plans, [or] health insurance producers, or
2133 health insurance premiums charged in the exchange;

2134 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or
2135 (iii) act as an appeals entity for resolving disputes between a health insurer and an
2136 insured; [and]
2137 (b) may establish and collect a fee in accordance with Section 63J-1-504 for:
2138 (i) the transaction cost of:
2139 [(i)] (A) processing an application for a health benefit plan [from the Internet portal to
2140 an insurer; and];
2141 [(ii)] (B) accepting, processing, and submitting multiple premium payment sources[.];
2142 and
2143 (C) providing a mechanism for consumers to filter and compare health benefit plans in
2144 the exchange based on consumer preferences; and
2145 (ii) funding the call center established in accordance with Subsection (3); and
2146 (c) shall separately itemize any fees established under Subsection (4)(b) as part of the
2147 cost displayed for the employer selecting coverage on the exchange.
2148 Section 32. Section **63M-1-2506** is amended to read:
2149 **63M-1-2506. Health benefit plan information on Health Insurance Exchange --**
2150 **Insurer transparency.**
2151 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,
2152 Chapter 3, Utah Administrative Rulemaking Act, [that:] that establish uniform electronic
2153 standards for insurers, employers, brokers, consumers, and vendors to use when transmitting or
2154 receiving information, uniform applications, waivers of coverage, or payments to, or from, the
2155 Health Insurance Exchange.
2156 [(i) establish uniform electronic standards for:]
2157 [(A) a health insurer to use when:]
2158 [(I) transmitting information to:]
2159 [(Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and]
2160 [(Bb) the Health Insurance Exchange as required by this section;]
2161 [(II) receiving information from the Health Insurance Exchange;]
2162 [(III) receiving or transmitting the universal health application to or from the Health
2163 Insurance Exchange;]
2164 [(B) facilitating the transmission and receipt of premium payments from multiple

2165 sources in the defined contribution arrangement market; and]
2166 [(C) the use of the uniform health insurance application required by Section
2167 31A-22-635 on the Health Insurance Exchange;]
2168 [(ii) designate the level of detail that would be helpful for a concise consumer
2169 comparison of the items described in Subsections (4) and (5) on the Health Insurance
2170 Exchange;]
2171 (b) The administrative rules adopted by the office shall:
2172 (i) promote an efficient and consumer friendly process for shopping for and enrolling
2173 in a health benefit plan offered on the Health Insurance Exchange; and
2174 (ii) if appropriate, as determined by the office, comply with standards adopted at the
2175 national level.
2176 [(iii)] (2) The office shall assist the risk adjuster board created under Title 31A,
2177 Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined
2178 contribution market on the Health Insurance Exchange with the determination of when an
2179 employer is eligible to participate in the Health Insurance Exchange under Title 31A, Chapter
2180 30, Part 2, Defined Contribution Arrangements[; and].
2181 [(iv)] (3) (a) The office shall create an advisory board to advise the exchange
2182 concerning the operation of the exchange, the consumer experience on the exchange, and
2183 transparency issues [with].
2184 (b) The advisory board shall have the following members:
2185 [(A)] (i) two health producers who are [registered] appointed producers with the Health
2186 Insurance Exchange;
2187 [(B) two consumers;]
2188 [(C) one representative from a large insurer who participates on the exchange;]
2189 [(D) one representative from a small insurer who participates on the exchange;]
2190 (ii) two representatives from community-based, non-profit organizations;
2191 (iii) one representative from an employer that participates in the defined contribution
2192 market on the Health Insurance Exchange;
2193 (iv) up to four representatives from insurers who participate in the defined contribution
2194 market of the Health Insurance Exchange;
2195 [(E)] (v) one representative from the [Insurance] Department of Commerce, which may

2196 delegate this function to the Division of Insurance; and
2197 [(F)] (vi) one representative from the Department of Health.
2198 (c) Members of the advisory board shall serve without compensation.
2199 [(b)] (4) The office shall post or facilitate the posting, on the Health Insurance
2200 Exchange, of[: (i)] the information required by this section [on the Health Insurance Exchange
2201 created by this part; and (ii)] and Section 31A-22-635 and links to websites that provide cost
2202 and quality information from the Department of Health Data Committee or neutral entities with
2203 a broad base of support from the provider and payer communities.
2204 [(2) A health insurer shall use the uniform electronic standards when transmitting
2205 information to the Health Insurance Exchange or receiving information from the Health
2206 Insurance Exchange.]
2207 [(3) (a) (i) An insurer who participates in the defined contribution arrangement market
2208 under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans
2209 offered in the defined contribution arrangement market on the Health Insurance Exchange and
2210 shall comply with the provisions of this section.]
2211 [(ii) Beginning January 1, 2013, an insurer who offers a health benefit plan to a small
2212 employer group in the state shall:]
2213 [(A) post the health benefit plans in which the insurer is enrolling new groups on the
2214 Health Insurance Exchange; and]
2215 [(B) comply with the provisions of this section.]
2216 [(b) An insurer who offers individual health benefit plans under Title 31A, Chapter 30,
2217 Part 1, Individual and Small Employer Group:]
2218 [(i) shall post on the Health Insurance Exchange the basic benefit plan required by
2219 Section 31A-22-613.5; and]
2220 [(ii) may publish on the Health Insurance Exchange any other health benefit plans that
2221 it offers in the individual market.]
2222 [(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:]
2223 [(i) shall comply with the provisions of this section for every health benefit plan it
2224 posts on the Health Insurance Exchange; and]
2225 [(ii) may not offer products on the Health Insurance Exchange that are not health
2226 benefit plans.]

2227 [(4) A health insurer shall provide the Health Insurance Exchange with the following
2228 information for each health benefit plan submitted to the Health Insurance Exchange:]
2229 [(a) plan design, benefits, and options offered by the health benefit plan including state
2230 mandates the plan does not cover;]
2231 [(b) provider networks;]
2232 [(c) wellness programs and incentives; and]
2233 [(d) descriptions of prescription drug benefits, exclusions, or limitations.]
2234 [(5) (a) An insurer offering any health benefit plan in the state shall submit the
2235 information described in Subsection (5)(b) to the Insurance Department in the electronic format
2236 required by Subsection (1).]
2237 [(b) An insurer who offers a health benefit plan in the state shall submit to the Health
2238 Insurance Exchange the following operational measures:]
2239 [(i) the percentage of claims paid by the insurer within 30 days of the date a claim is
2240 submitted to the insurer for the prior year; and]
2241 [(ii) for all health benefit plans offered by the insurer in the state, the claims denial and
2242 insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).]
2243 [(c) The Insurance Department shall forward to the Health Insurance Exchange the
2244 information submitted by an insurer in accordance with this section and Section
2245 31A-22-613.5.]
2246 [(6) The Insurance Department shall post on the Health Insurance Exchange the
2247 Insurance Department's solvency rating for each insurer who posts a health benefit plan on the
2248 Health Insurance Exchange. The solvency rating for each carrier shall be based on
2249 methodology established by the Insurance Department by administrative rule and shall be
2250 updated each calendar year.]
2251 [(7) The commissioner may request information from an insurer under Section
2252 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health
2253 Insurance Exchange under this section.]
2254 [(8) A health insurer shall accept and process an application for a health benefit plan
2255 from the Health Insurance Exchange in accordance with this section and Section 31A-22-635.]
2256 Section 33. Section **72-6-107.5** is amended to read:
2257 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**

2258 **insurance coverage.**
2259 (1) For purposes of this section:
2260 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2261 34A-2-104 who:
2262 (i) works at least 30 hours per calendar week; and
2263 (ii) meets employer eligibility waiting requirements for health care insurance which
2264 may not exceed the first day of the calendar month following 90 days from the date of hire.
2265 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
2266 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
2267 ~~or renewed:~~] is as defined in Section 26-40-115.
2268 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
2269 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
2270 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
2271 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
2272 ~~employee who reside or work in the state, in which:~~]
2273 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
2274 ~~dependents of the employee who reside or work in the state; and~~]
2275 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):~~]
2276 [~~(I) rather that the benchmark plan's deductible, and the benchmark plan's~~
2277 ~~out-of-pocket maximum based on income levels:~~]
2278 [~~(Aa) the deductible is $750 per individual and $2,250 per family; and~~]
2279 [~~(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;~~]
2280 [~~(II) dental coverage is not required; and~~]
2281 [~~(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
2282 ~~not apply; or~~]
2283 [~~(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
2284 ~~deductible that is either:~~]
2285 [~~(I) the lowest deductible permitted for a federally qualified high deductible health~~
2286 ~~plan; or~~]
2287 [~~(II) a deductible that is higher than the lowest deductible permitted for a federally~~
2288 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~

2289 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
2290 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
2291 ~~employer offered federally qualified high deductible plan;~~]
2292 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
2293 ~~annual deductible; and~~]
2294 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
2295 ~~dependents of the employee who work or reside in the state.~~]
2296 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
2297 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered
2298 into by the department on or after July 1, 2009, for construction or design of highways and to a
2299 prime contractor or to a subcontractor in accordance with Subsection (2)(b).
2300 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2301 amount of $1,500,000 or greater.
2302 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2303 $750,000 or greater.
2304 (3) This section does not apply if:
2305 (a) the application of this section jeopardizes the receipt of federal funds;
2306 (b) the contract is a sole source contract; or
2307 (c) the contract is an emergency procurement.
2308 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]
2309 63G-6-103, or a modification to a contract, when the contract does not meet the initial
2310 threshold required by Subsection (2).
2311 (b) A person who intentionally uses change orders or contract modifications to
2312 circumvent the requirements of Subsection (2) is guilty of an infraction.
2313 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
2314 the contractor has and will maintain an offer of qualified health insurance coverage for the
2315 contractor's employees and the employees' dependents during the duration of the contract.
2316 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
2317 demonstrate to the department that the subcontractor has and will maintain an offer of qualified
2318 health insurance coverage for the subcontractor's employees and the employees' dependents
2319 during the duration of the contract.

2320 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2321 the duration of the contract is subject to penalties in accordance with administrative rules
2322 adopted by the department under Subsection (6).
2323 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2324 requirements of Subsection (5)(b).
2325 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2326 the duration of the contract is subject to penalties in accordance with administrative rules
2327 adopted by the department under Subsection (6).
2328 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2329 requirements of Subsection (5)(a).
2330 (6) The department shall adopt administrative rules:
2331 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
2332 (b) in coordination with:
2333 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
2334 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
2335 (iii) the State Building Board in accordance with Section 63A-5-205;
2336 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
2337 (v) a public transit district in accordance with Section 17B-2a-818.5; and
2338 (vi) the Legislature's Administrative Rules Review Committee; and
2339 (c) which establish:
2340 (i) the requirements and procedures a contractor must follow to demonstrate to the
2341 department compliance with this section which shall include:
2342 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2343 (b) more than twice in any 12-month period; and
2344 (B) that the actuarially equivalent determination required for qualified health insurance
2345 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2346 division with a written statement of actuarial equivalency from either:
2347 (I) the Utah Insurance Department;
2348 (II) an actuary selected by the contractor or the contractor's insurer; or
2349 (III) an underwriter who is responsible for developing the employer group's premium
2350 rates;

2351 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2352 violates the provisions of this section, which may include:
2353 (A) a three-month suspension of the contractor or subcontractor from entering into
2354 future contracts with the state upon the first violation;
2355 (B) a six-month suspension of the contractor or subcontractor from entering into future
2356 contracts with the state upon the second violation;
2357 (C) an action for debarment of the contractor or subcontractor in accordance with
2358 Section 63G-6-804 upon the third or subsequent violation; and
2359 (D) monetary penalties which may not exceed 50% of the amount necessary to
2360 purchase qualified health insurance coverage for an employee and a dependent of the employee
2361 of the contractor or subcontractor who was not offered qualified health insurance coverage
2362 during the duration of the contract; and
2363 (iii) a website on which the department shall post the benchmark for the qualified
2364 health insurance coverage identified in Subsection (1)(c)[~~(i)~~].
2365 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2366 subcontractor who intentionally violates the provisions of this section shall be liable to the
2367 employee for health care costs that would have been covered by qualified health insurance
2368 coverage.
2369 (ii) An employer has an affirmative defense to a cause of action under Subsection
2370 (7)(a)(i) if:
2371 (A) the employer relied in good faith on a written statement of actuarial equivalency
2372 provided by:
2373 (I) an actuary; or
2374 (II) an underwriter who is responsible for developing the employer group's premium
2375 rates; or
2376 (B) the department determines that compliance with this section is not required under
2377 the provisions of Subsection (3) or (4).
2378 (b) An employee has a private right of action only against the employee's employer to
2379 enforce the provisions of this Subsection (7).
2380 (8) Any penalties imposed and collected under this section shall be deposited into the
2381 Medicaid Restricted Account created in Section 26-18-402.

2382 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2383 coverage as required by this section:
2384 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2385 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2386 Legal and Contractual Remedies; and
2387 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2388 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2389 or construction.
2390 Section 34. Section **79-2-404** is amended to read:
2391 **79-2-404. Contracting powers of department -- Health insurance coverage.**
2392 (1) For purposes of this section:
2393 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2394 34A-2-104 who:
2395 (i) works at least 30 hours per calendar week; and
2396 (ii) meets employer eligibility waiting requirements for health care insurance which
2397 may not exceed the first day of the calendar month following 90 days from the date of hire.
2398 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
2399 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
2400 ~~or renewed:~~] is as defined in Section 26-40-115.
2401 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
2402 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
2403 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
2404 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
2405 ~~employee who reside or work in the state, in which:~~]
2406 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
2407 ~~dependents of the employee who reside or work in the state; and~~]
2408 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):~~]
2409 [~~(I) rather that the benchmark plan's deductible, and the benchmark plan's~~
2410 ~~out-of-pocket maximum based on income levels:~~]
2411 [~~(Aa) the deductible is $750 per individual and $2,250 per family; and~~]
2412 [~~(Bb) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;~~]

2413 [~~(II) dental coverage is not required; and~~]
2414 [~~(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
2415 ~~not apply; or~~]
2416 [~~(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
2417 ~~deductible that is either:~~]
2418 [~~(I) the lowest deductible permitted for a federally qualified high deductible health~~
2419 ~~plan; or~~]
2420 [~~(II) a deductible that is higher than the lowest deductible permitted for a federally~~
2421 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
2422 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
2423 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
2424 ~~employer offered federally qualified high deductible plan;~~]
2425 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
2426 ~~annual deductible; and~~]
2427 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
2428 ~~dependents of the employee who work or reside in the state.~~]
2429 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
2430 (2) (a) Except as provided in Subsection (3), this section applies a design or
2431 construction contract entered into by, or delegated to, the department or a division, board, or
2432 council of the department on or after July 1, 2009, and to a prime contractor or to a
2433 subcontractor in accordance with Subsection (2)(b).
2434 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2435 amount of $1,500,000 or greater.
2436 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2437 $750,000 or greater.
2438 (3) This section does not apply to contracts entered into by the department or a
2439 division, board, or council of the department if:
2440 (a) the application of this section jeopardizes the receipt of federal funds;
2441 (b) the contract or agreement is between:
2442 (i) the department or a division, board, or council of the department; and
2443 (ii) (A) another agency of the state;

2444 (B) the federal government;
2445 (C) another state;
2446 (D) an interstate agency;
2447 (E) a political subdivision of this state; or
2448 (F) a political subdivision of another state; or
2449 (c) the contract or agreement is:
2450 (i) for the purpose of disbursing grants or loans authorized by statute;
2451 (ii) a sole source contract; or
2452 (iii) an emergency procurement.
2453 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]
2454 63G-6-103, or a modification to a contract, when the contract does not meet the initial
2455 threshold required by Subsection (2).
2456 (b) A person who intentionally uses change orders or contract modifications to
2457 circumvent the requirements of Subsection (2) is guilty of an infraction.
2458 (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department
2459 that the contractor has and will maintain an offer of qualified health insurance coverage for the
2460 contractor's employees and the employees' dependents during the duration of the contract.
2461 (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor
2462 shall demonstrate to the department that the subcontractor has and will maintain an offer of
2463 qualified health insurance coverage for the subcontractor's employees and the employees'
2464 dependents during the duration of the contract.
2465 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2466 the duration of the contract is subject to penalties in accordance with administrative rules
2467 adopted by the department under Subsection (6).
2468 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2469 requirements of Subsection (5)(b).
2470 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2471 the duration of the contract is subject to penalties in accordance with administrative rules
2472 adopted by the department under Subsection (6).
2473 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2474 requirements of Subsection (5)(a).

2475 (6) The department shall adopt administrative rules:
2476 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
2477 (b) in coordination with:
2478 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
2479 (ii) a public transit district in accordance with Section 17B-2a-818.5;
2480 (iii) the State Building Board in accordance with Section 63A-5-205;
2481 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
2482 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
2483 (vi) the Legislature's Administrative Rules Review Committee; and
2484 (c) which establish:
2485 (i) the requirements and procedures a contractor must follow to demonstrate
2486 compliance with this section to the department which shall include:
2487 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2488 (b) more than twice in any 12-month period; and
2489 (B) that the actuarially equivalent determination required for qualified health insurance
2490 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2491 division with a written statement of actuarial equivalency from either:
2492 (I) the Utah Insurance Department;
2493 (II) an actuary selected by the contractor or the contractor's insurer; or
2494 (III) an underwriter who is responsible for developing the employer group's premium
2495 rates;
2496 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2497 violates the provisions of this section, which may include:
2498 (A) a three-month suspension of the contractor or subcontractor from entering into
2499 future contracts with the state upon the first violation;
2500 (B) a six-month suspension of the contractor or subcontractor from entering into future
2501 contracts with the state upon the second violation;
2502 (C) an action for debarment of the contractor or subcontractor in accordance with
2503 Section 63G-6-804 upon the third or subsequent violation; and
2504 (D) monetary penalties which may not exceed 50% of the amount necessary to
2505 purchase qualified health insurance coverage for an employee and a dependent of an employee

2506 of the contractor or subcontractor who was not offered qualified health insurance coverage
2507 during the duration of the contract; and
2508 (iii) a website on which the department shall post the benchmark for the qualified
2509 health insurance coverage identified in Subsection (1)(c)[~~(i)~~].
2510 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2511 subcontractor who intentionally violates the provisions of this section shall be liable to the
2512 employee for health care costs that would have been covered by qualified health insurance
2513 coverage.
2514 (ii) An employer has an affirmative defense to a cause of action under Subsection
2515 (7)(a)(i) if:
2516 (A) the employer relied in good faith on a written statement of actuarial equivalency
2517 provided by:
2518 (I) an actuary; or
2519 (II) an underwriter who is responsible for developing the employer group's premium
2520 rates; or
2521 (B) the department determines that compliance with this section is not required under
2522 the provisions of Subsection (3) or (4).
2523 (b) An employee has a private right of action only against the employee's employer to
2524 enforce the provisions of this Subsection (7).
2525 (8) Any penalties imposed and collected under this section shall be deposited into the
2526 Medicaid Restricted Account created in Section 26-18-402.
2527 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2528 coverage as required by this section:
2529 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2530 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2531 Legal and Contractual Remedies; and
2532 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2533 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2534 or construction.
2535 Section 35. **Repealer.**
2536 This bill repeals:

2537 Section **31A-42a-101 (Effective 01/01/13), Title.**

2538 Section **31A-42a-102 (Effective 01/01/13), Definitions.**

2539 Section **31A-42a-201 (Effective 01/01/13), Creation of defined contribution market**
2540 **risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan**
2541 **preparation.**

2542 Section **31A-42a-202 (Effective 01/01/13), Contents of plan.**

2543 Section **31A-42a-203 (Effective 01/01/13), Powers and duties of board.**

2544 Section **31A-42a-204 (Effective 01/01/13), Powers of commissioner.**

2545 Section 36. **Health System Reform Task Force -- Creation -- Membership --**
2546 **Interim rules followed -- Compensation -- Staff.**

2547 (1) There is created the Health System Reform Task Force consisting of the following
2548 11 members:

2549 (a) four members of the Senate appointed by the president of the Senate, no more than
2550 three of whom may be from the same political party; and

2551 (b) seven members of the House of Representatives appointed by the speaker of the
2552 House of Representatives, no more than five of whom may be from the same political party.

2553 (2) (a) The president of the Senate shall designate a member of the Senate appointed
2554 under Subsection (1)(a) as a cochair of the committee.

2555 (b) The speaker of the House of Representatives shall designate a member of the House
2556 of Representatives appointed under Subsection (1)(b) as a cochair of the committee.

2557 (3) In conducting its business, the committee shall comply with the rules of legislative
2558 interim committees.

2559 (4) Salaries and expenses of the members of the committee shall be paid in accordance
2560 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
2561 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
2562 Sessions.

2563 (5) The Office of Legislative Research and General Counsel shall provide staff support
2564 to the committee.

2565 Section 37. **Duties -- Interim report.**

2566 (1) The task force shall review and make recommendations on the following issues:

2567 (a) the state's response to federal health care reform, including whether the state should

2568 develop an American Health Benefit Exchange under the federal Affordable Care Act for
2569 individual health benefit plans, individual premium assistance, tax credits, and Medicaid
2570 eligibility determinations;
2571 (b) legislation necessary to implement:
2572 (i) the governance structure for the Health Insurance Exchange as an independent state
2573 agency governed by an executive director, a commission, and a board of trustees whose
2574 purpose is to preserve the market-based defined contribution model for employers in the Health
2575 Insurance Exchange;
2576 (ii) an operational blue print for the Health Insurance Exchange to promote an
2577 appropriate balance between private sector solutions and efficiencies for the exchange and state
2578 regulatory functions related to insurance market conduct; and
2579 (iii) funding requirements associated with the governance structure;
2580 (c) whether the Health Insurance Exchange model needs to be, or should be modified
2581 to qualify as a SHOP Exchange under the federal Affordable Care Act;
2582 (d) which market regulatory functions should be given to the Health Insurance
2583 Exchange and which should remain with the Insurance Department, the Department of Health,
2584 or the Department of Workforce Services;
2585 (e) policy and guidance regarding the state's implementation of the small group defined
2586 contribution arrangement market on the Health Insurance Exchange, including the consumer
2587 experience and information on the exchange concerning cost, quality, and transparency;
2588 (f) whether the risk adjuster mechanism in the exchange should be modified in
2589 response to the requirements of federal health care reform;
2590 (g) health care cost containment issues, including:
2591 (i) progress on the demonstration projects and grants that involve health care providers
2592 and payers to provide systemwide aligned incentives for the appropriate delivery of, and
2593 payment for, health care; and
2594 (ii) effective tools for reducing the cost or perceived costs of medical malpractice
2595 liability in the health care system; and
2596 (h) the appropriate balance of cost and benefits provided by insurance plans available
2597 on the exchange, including possible consideration of spiritual care, vision care, and dental
2598 services.

2599 (2) A final report, including any proposed legislation shall be presented to the Health
2600 and Human Services Interim Committee before November 30, 2011.
2601 Section 38. **Intent language regarding lapsing of money.**
2602 It is the intent of the Legislature that money received by the Insurance Department
2603 during fiscal year 2010-11 under Section 31A-30-115 shall be considered dedicated credits and
2604 in closing out the fiscal year 2010-11 the unspent dedicated credits shall lapse to the Health
2605 Insurance Actuarial Review Restricted Account.
2606 Section 39. **Repeal date.**
2607 (1) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Sections 48 and 49,
2608 which enacted the 2010 Health System Reform Task Force.
2609 (2) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Section 50,
2610 Subsection (3), which provided a future effective date of January 1, 2013, for Title 31A,
2611 Chapter 42a, Utah Statewide Risk Adjuster Act.
2612 (3) The Health System Reform Task Force created in Sections 34 and 35 of this bill is
2613 repealed on December 30, 2011.

FISCAL NOTE

H.B. 128 1st Sub. (Buff)

SHORT TITLE: Health Reform Amendments

SPONSOR: Dunnigan, J.

2011 GENERAL SESSION, STATE OF UTAH

STATE GOVERNMENT (UCA 36-12-13(2)(b))

Enactment of this bill will create a General Fund Restricted Account within the Insurance Department called the Health Insurance Actuarial Review Restricted Account. Current annual assessments for these reviews total $150,000 with 15 providers having premiums written in the state. Cost for the actuary is estimated at $147,000 per fiscal year.

Additionally, the cost of one meeting for the Health System Reform Taskforce would be $3,800. However, the bill does not specify the number of meetings for the Taskforce in one fiscal year, so the actual cost may become higher depending upon the number of meetings.

STATE BUDGET DETAIL TABLE	FY 2011	FY 2012	FY 2013
Revenue:			
General Fund Restricted	$0	$150,000	$150,000
Total Revenue	$0	$150,000	$150,000
Expenditure:			
General Fund	$0	$3,800	$3,800
General Fund Restricted	$0	$147,000	$147,000
Total Expenditure	$0	$150,800	$150,800
Net Impact, All Funds (Rev.-Exp.)	$0	($800)	($800)
Net Impact, General/Education Funds	$0	($3,800)	($3,800)

LOCAL GOVERNMENTS (UCA 36-12-13(2)(c))

Enactment of this bill likely will not result in direct, measurable costs for local governments.

DIRECT EXPENDITURES BY UTAH RESIDENTS AND BUSINESSES (UCA 36-12-13(2)(d))

Small employer carriers participating in the defined contribution arrangement market and small employer carriers offering health benefit plans will be assessed a fee by the Insurance Department to cover the costs of actuarial review each year, currently $150,000 in total costs. Additionally, Health Benefit Plan Providers will be assessed a fee to fund the call centers, however, the exact fee cannot be determined until the actual costs for call centers are determined in the requests for proposals and awarded contracts.

2/24/2011, 06:51 PM, Lead Analyst: Lee, P.W./Attorney: CJD

Office of the Legislative Fiscal Analyst