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H.B. 128
2nd Sub. (Gray)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH REFORM AMENDMENTS

2011 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: John L. Valentine

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

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

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- requires group health benefit plans to have reasonable plan premium rates and to comply with standards established by the Insurance Department;
- amends small group mental health offering;
- amends provisions related to Utah NetCare;
- amends provisions related to the basic health care plan;
- prohibits an insurance customer representative from practicing independent of a producer or consultant employer, and limits a customer service representative's authority to bind coverage;
- amends small group case characteristics and allows premiums to vary based on gender;
- gives the Insurance Department the responsibility to conduct an actuarial review of rates established for the health benefit plan market;
- authorizes the department to establish a fee for the actuarial review;
- amends provisions related to the appointment of brokers to the Health Insurance Exchange;
- removes language from the Risk Adjuster Board chapter of the Insurance Code related to the actuarial review of rates;
- establishes the money in the Health Insurance Actuarial Review Restricted Account as non-lapsing;
- removes the large group market from the Health Insurance Exchange;
- clarifies the authority of the Office of Consumer Health Services to:
  - contract with private entities for the purpose of administering functions of the Health Insurance Exchange;
  - establish a call center for customer service in the exchange; and
  - charge a fee for certain functions of the exchange;
- moves language regarding insurance regulation from the Office of Consumer Health Services to the Insurance Code;
- reauthorizes the Health System Reform Task Force, including:
  - membership of the task force; and
  - duties of the task force;
- creates the Health Insurance Actuarial Review Restricted Account;

- provides intent language that fees received by the Insurance Department in 2010, for the department's actuarial review as dedicated credits, shall lapse to the Health Insurance Actuarial Review Restricted Account;
- repeals the statewide risk adjuster mechanism that was effective January 1, 2013; and
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a repeal date for certain provisions.

Utah Code Sections Affected:

AMENDS:

17B-2a-818.5, as last amended by Laws of Utah 2010, Chapter 229

19-1-206, as last amended by Laws of Utah 2010, Chapters 218 and 229

26-33a-102, as last amended by Laws of Utah 1996, Chapter 232

26-33a-103, as last amended by Laws of Utah 2010, Chapter 286

26-33a-106.5, as last amended by Laws of Utah 2005, Chapter 266

26-40-106, as last amended by Laws of Utah 2007, Chapter 47

31A-2-212, as last amended by Laws of Utah 2007, Chapter 309

31A-22-613.5, as last amended by Laws of Utah 2010, Chapters 68, 149 and last amended by Coordination Clause, Laws of Utah 2010, Chapter 149

31A-22-614.6, as last amended by Laws of Utah 2010, Chapter 68

31A-22-625, as last amended by Laws of Utah 2010, Chapters 10 and 68

31A-22-635, as last amended by Laws of Utah 2010, Chapter 68

31A-22-724, as enacted by Laws of Utah 2009, Chapter 12

31A-29-103, as last amended by Laws of Utah 2008, Chapters 3 and 385

31A-30-103, as last amended by Laws of Utah 2010, Chapter 68

31A-30-104, as last amended by Laws of Utah 2009, Chapter 12

31A-30-106.1, as enacted by Laws of Utah 2010, Chapter 68

31A-30-203, as last amended by Laws of Utah 2010, Chapter 68

31A-30-205, as last amended by Laws of Utah 2010, Chapters 68, 149 and last

amended by Coordination Clause, Laws of Utah 2010, Chapter 149

31A-30-207, as last amended by Laws of Utah 2010, Chapter 68

31A-30-208, as repealed and reenacted by Laws of Utah 2010, Chapter 68

31A-30-209, as enacted by Laws of Utah 2010, Chapter 68

31A-42-202, as last amended by Laws of Utah 2010, Chapter 68

63A-5-205, as last amended by Laws of Utah 2010, Chapter 229

63C-9-403, as last amended by Laws of Utah 2010, Chapter 229

63I-1-231, as last amended by Laws of Utah 2010, Chapters 68 and 319

63J-1-602.2, as enacted by Laws of Utah 2010, Chapter 265 and last amended by Coordination Clause, Laws of Utah 2010, Chapter 265

63M-1-2504, as last amended by Laws of Utah 2010, Chapter 68

63M-1-2506, as last amended by Laws of Utah 2010, Chapter 68

72-6-107.5, as last amended by Laws of Utah 2010, Chapter 229

79-2-404, as last amended by Laws of Utah 2010, Chapter 229

ENACTS:

26-1-39, Utah Code Annotated 1953

26-40-115, Utah Code Annotated 1953

31A-23a-115.5, Utah Code Annotated 1953

31A-30-115, Utah Code Annotated 1953

31A-30-211, Utah Code Annotated 1953

REPEALS:

31A-42a-101 (Effective 01/01/13), as enacted by Laws of Utah 2010, Chapter 68

31A-42a-102 (Effective 01/01/13), as enacted by Laws of Utah 2010, Chapter 68

31A-42a-201 (Effective 01/01/13), as enacted by Laws of Utah 2010, Chapter 68

31A-42a-202 (Effective 01/01/13), as enacted by Laws of Utah 2010, Chapter 68

31A-42a-203 (Effective 01/01/13), as enacted by Laws of Utah 2010, Chapter 68

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

Uncodified Material Affected:

ENACTS UNCODIFIED MATERIAL

REPEALS UNCODIFIED MATERIAL:

Laws of Utah 2010, Chapter 68, Uncodified Section 48

Laws of Utah 2010, Chapter 68, Uncodified Section 49

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

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

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

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

district that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employee's dependents during the duration of the contract.

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

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

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

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

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

(6) The public transit district shall adopt ordinances:

(a) in coordination with:

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

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

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

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

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

(b) which establish:

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

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

(B) that the actuarially equivalent determination required <u>for the qualified health insurance coverage</u> in Subsection (1) is met by the contractor if the contractor provides the

department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

(I) actuary; or

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

(B) a department or division determines that compliance with this section is not

required under the provisions of Subsection (3) or (4).

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

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

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

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

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

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

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

or board of the department if:

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

(b) the contract or agreement is between:

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

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

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

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

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

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

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

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

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

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

department under Subsection (6).

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

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

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

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

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

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

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

26-33a-102. Definitions.

As used in this chapter:

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

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

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

(4) "Disclosure" or "disclose" means the communication of health care data to any individual or organization outside the committee, its staff, and contracting agencies.

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

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

(7) "Health care provider" means any person, partnership, association, corporation, or

other facility or institution that renders or causes to be rendered health care or professional services as a physician, registered nurse, licensed practical nurse, nurse-midwife, dentist, dental hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, podiatric physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist, speech pathologist, certified social worker, social service worker, social service aide, marriage and family counselor, or practitioner of obstetrics, and others rendering similar care and services relating to or arising out of the health needs of persons or groups of persons, and officers, employees, or agents of any of the above acting in the course and scope of their employment.

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

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

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

(11) "Individual" means a natural person.

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

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

(a) describing the group characteristics of individuals or organizations;

(b) analyzing the noncompliance among the various characteristics of individuals or organizations;

(c) conducting statistical procedures or studies to improve the quality of health data;

(d) designing sample surveys and selecting samples of individuals or organizations; and

(e) preparing and publishing reports describing these matters.

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

payments.

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

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

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

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

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

(d) a corporation, organization, association, entity, or person[~~.~~]:

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

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

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

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

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

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

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

(4) The membership of the committee shall be:

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

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

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

(ii) who actively practice medicine in this state;

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

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

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

[~~(d)~~] (c) three persons:

(i) who are:

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

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

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

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

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

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

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

[~~(f)~~] (e) two consumer representatives:

(i) from organized consumer or employee associations; and

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

[~~(g)~~] (f) one person [~~broadly~~]:

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

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

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

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

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

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

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

(ii) prior to July 1, 2011, re-appoint the members described in Subsections (4)(b), (d), and (f) as necessary to comply with changes in eligibility for membership that were enacted during the 2011 General Session.

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

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

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

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

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

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

(a) Section 63A-3-106;

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

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

63A-3-107.

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

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

26-33a-106.5. Comparative analyses.

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

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

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

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

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

(i) be published at least annually; and

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

(A) nationally or other generally recognized quality standards;

(B) charges; and

(C) nationally recognized patient safety standards.

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

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

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

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

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

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

(i) routine and preventive care; and

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

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

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

(i) results for health care facilities or institutions;

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

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

(d) The department:

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

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

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

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

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

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

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

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

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

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

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

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

26-40-106. Program benefits.

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

(a) hospital services;

(b) physician services;

(c) laboratory services;

(d) prescription drugs;

(e) mental health services;

(f) basic dental services;

(g) preventive care including:

(i) routine physical examinations;

(ii) immunizations;

(iii) basic vision services; and

(iv) basic hearing services;

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

(i) hospice care.

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

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

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

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

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

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

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

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

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

(1) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and

a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

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

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

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

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

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

(ii) dental coverage is not required; and

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

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

(a) has a deductible that is either:

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

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

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

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

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

31A-2-212. Miscellaneous duties.

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

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

and

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

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

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

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

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

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

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

(i) an authorized insurer doing a surety business:

(A) files a petition for receivership; or

(B) is in receivership; or

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

(A) is in financial difficulty; or

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

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

with a new surety.

(5) The commissioner shall require an insurer that issues, sells, renews, or offers health insurance coverage in this state to comply with:

(a) the Health Insurance Portability and Accountability Act, [~~P.L. 104-191~~] Pub. L. No. 104-191, pursuant to 110 Stat. 1968, Sec. 2722[.]; and

(b) subject to Section 63M-1-2505.5, and to the extent required or applicable under the provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, related to regulation of health benefit plans, including:

(i) lifetime and annual limits;

(ii) prohibition of rescissions;

(iii) coverage of preventive health services;

(iv) coverage for a child or dependent;

(v) pre-existing condition coverage for children;

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

(vii) premium rate reviews;

(viii) essential benefits;

(ix) provider choice;

(x) waiting periods; and

(xi) appeals processes.

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

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

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

(b) Subsection (2) applies to:

(i) all health benefit plans; and

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

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

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

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

(I) the use of a formulary;

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

(III) requirements for generic substitution;

(B) coverage limits under the plan; and

(C) any limitation or exclusion of coverage including:

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

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

(ii) provide the commissioner with:

(A) the information described in Subsections [~~63M-1-2506(3) through (6)~~] 31A-22-635(5) through (7) in the standardized electronic format required by Subsection 63M-1-2506(1); and

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

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

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):

(A) treatment policies;

(B) practice standards;

(C) restrictions;

(D) coverage limits of the insurer's health benefit plan or health insurance policy; or

(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

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

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

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

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

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

(ii) Examples of a limitation or exclusion of coverage provided under Subsection (2)(a)(i)(C) or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) consumer assessment of each insurer or health benefit plan;

(b) adopt an administrative rule that establishes:

(i) definition of terms;

(ii) the methodology for determining and comparing the insurer transparency information;

(iii) the data, and format of the data, that an insurer must submit to the [~~department~~] commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(iv) the dates on which the insurer must submit the data to the [~~department~~] commissioner in order for the [~~department~~] commissioner to transmit the data to the Health Insurance Exchange in accordance with Section 63M-1-2506; and

(c) implement the rules adopted under Subsection [~~(5)~~] (4)(b) in a manner that protects the business confidentiality of the insurer.

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

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

(1) The Legislature finds that:

(a) current health care delivery and payment systems do not provide systemwide aligned incentives for the appropriate delivery of health care;

(b) some health care providers and health care payers have developed ideas for health care delivery and payment system reform, but lack the critical number of patient lives and payer involvement to accomplish systemwide reform; and

(c) there is a compelling state interest to encourage [~~as many~~] health care providers and health care payers to join together and coordinate efforts at systemwide health care delivery and payment reform.

(2) (a) The [~~Office of Consumer Health Services within the Governor's Office of Economic Development shall~~] Department of Health may convene meetings of health care providers and health care payers [~~through a neutral, non-biased entity that can demonstrate it has the support of a broad base of the participants in this process~~] for the purpose of coordinating broad based demonstration projects for health care delivery and payment reform.

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

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

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

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

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

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

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

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

(4) The [~~Office of Consumer Health Services~~] Department of Health and the commissioner shall report to the Health System Reform Task Force by October [~~2010~~] 2011,

and to the Legislature's Business and Labor Interim Committee every October thereafter regarding the progress towards coordination of broad based health care system payment and delivery reform.

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

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

(1) As used in this section:

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

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

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

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

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

(A) episodic limits;

(B) inpatient or outpatient service limits; or

(C) maximum out-of-pocket limits.

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

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

(ii) "Mental health condition" does not include the following when diagnosed as the

primary or substantial reason or need for treatment:

(A) a marital or family problem;

(B) a social, occupational, religious, or other social maladjustment;

(C) a conduct disorder;

(D) a chronic adjustment disorder;

(E) a psychosexual disorder;

(F) a chronic organic brain syndrome;

(G) a personality disorder;

(H) a specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between:

(i) (A) catastrophic mental health coverage [~~and~~]; or

(B) federally qualified mental health coverage as described in Subsection (3); and

(ii) 50/50 mental health coverage.

(b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions, choose either [~~catastrophic mental health coverage, 50/50 mental health coverage, or~~]:

(i) coverage offered under Subsection (2)(a)(i);

(ii) 50/50 mental health coverage; or

(iii) coverage offered under Subsection (2)(b)[~~, regardless of the employer's previous coverage for mental health conditions~~].

(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental

health coverage.

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

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

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

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

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

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

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

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

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

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

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

(ii) in a health care facility:

(A) licensed or otherwise authorized to provide mental health services pursuant to:

(I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

(B) that provides a program for the treatment of a mental health condition pursuant to a

written plan.

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

(6) The commissioner shall:

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

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

(i) no mental health coverage;

(ii) 50/50 mental health coverage;

(iii) catastrophic mental health coverage; and

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

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

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

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

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

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

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

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

(2) (a) Insurers offering a health benefit plan to an individual or small employer shall[~~: (i) except as provided in Subsection (6),~~] use a uniform application form[~~, which, beginning October 1, 2010:~~].

(b) The uniform application form:

[~~(A)~~] (i) except for cancer and transplants, may not include questions about an applicant's health history prior to the previous [~~10~~] five years; and

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

[~~(ii)~~] (c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which[~~: (A)~~] may not include health status related questions other

than pregnancy[~~;~~], and [~~(B)~~] is limited to:

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

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

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

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

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

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

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

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

[~~(ii) Modifications to the uniform application necessary to facilitate the electronic submission and processing of an application through the Health Insurance Exchange shall be adopted by administrative rule adopted by the Office of Consumer Health Services in accordance with Section 63M-1-2506.~~]

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

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

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

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

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

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

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

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

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

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

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

(c) wellness programs and incentives;

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

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

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

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

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

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

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

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

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

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

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

(b) [~~the~~] a high deductible and low deductible Utah NetCare Plans described in Subsection (2) as an alternative to COBRA and mini-COBRA [~~policies~~] health benefit plan coverage offered under Section 31A-22-722.

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

(a) healthy lifestyle and wellness incentives;

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

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

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

(e) the following deductibles:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) the following benefits before applying [~~any~~] a deductible [~~requirements~~] requirement and in accordance with [~~IRC~~] Section 223, Internal Revenue Code, and 42 U.S.C. Sec. 300gg-13:

(i) all well child exams and immunizations up to age five, with no annual maximum;

(ii) preventive care up to a $500 annual maximum;

(iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i) or (ii) up to a $300 annual maximum; and

(iv) supplemental accident coverage up to a $500 annual maximum;

(h) the following copayments for each exam:

(i) $15 for preventive care and well child exams;

(ii) $25 for primary care; and

(iii) $50 for urgent care and specialist care;

(i) a $200 copayment for an emergency room [~~visits~~] visit after applying the deductible;

(j) no more than a 30% coinsurance after deductible for covered plan benefits for:

(i) hospital services[~~,~~];

(ii) maternity[~~,~~];

(iii) laboratory work[~~,~~];

(iv) x-rays[~~,~~];

(v) radiology[~~,~~];

(vi) outpatient surgery services[~~,~~];

(vii) injectable medications not otherwise covered under a pharmacy benefit[~~,~~];

(viii) durable medical equipment[~~,~~];

(ix) ambulance services[~~,~~];

(x) in-patient mental health services[~~,~~]; and

(xi) out-patient mental health services; and

(k) the following cost-sharing features for a prescription [~~drugs~~] drug:

(i) up to a $15 copayment for a generic [~~drugs;~~] drug; and

(ii) up to a 50% coinsurance for a name brand [~~drugs; and~~] drug.

[~~(iii) may include formularies and preferred drug lists.~~]

(3) [~~The~~] A Utah NetCare [~~Plans~~] Plan may exclude:

(a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and

(b) unless required by federal law, mandated coverage required by the following sections and related administrative rules:

(i) Section 31A-22-610.1, Adoption indemnity [~~benefits~~] benefit;

(ii) Section 31A-22-623, Coverage of inborn metabolic errors;

(iii) Section 31A-22-624, Primary care [~~physicians~~] physician;

(iv) Section 31A-22-626, Coverage of diabetes;

(v) Section 31A-22-628, Standing referral to a specialist; and

(vi) [~~coverage mandates~~] a mandated coverage enacted after January 1, 2009, that [~~are~~] is not required by federal law.

[~~(4) (a) Beginning January 1, 2010, and except~~]

(4) A Utah NetCare Plan may include a formulary or preferred drug list.

(5) (a) Except as provided in Subsection [~~(5)~~] (6), a person may elect alternative coverage under this section if the person is eligible for:

(i) [~~is eligible for~~] continuation of employer group health benefit plan coverage under federal COBRA laws;

(ii) [~~is eligible for~~] continuation of employer group health benefit plan coverage under state mini-COBRA under Section 31A-22-722; or

(iii) [~~is eligible for~~] a conversion to an individual health benefit plan after the exhaustion of benefits under:

(A) alternative coverage elected in place of federal COBRA; or

(B) state mini-COBRA under Section 31A-22-722.

(b) The right to extend coverage under Subsection [~~(4)~~] (5)(a) applies to [~~any~~] spouse or dependent coverages, including a surviving spouse or dependent whose coverage under the policy terminates by reason of the death of the employee or member.

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

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

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

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

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

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

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

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

A customer service representative licensed under this chapter:

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

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

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

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

31A-29-103. Definitions.

As used in this chapter:

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

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

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

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

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

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

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

(5) "Health benefit plan":

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

(b) does not include a plan that:

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

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

(ii) meets other criteria established by the board.

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

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

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

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

(6) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(7) "Health care insurance" is defined in Section 31A-1-301.

(8) "Health care provider" has the same meaning as provided in Section 78B-3-403.

(9) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(10) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(11) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(a) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(b) coverage through:

(i) a health maintenance organization;

(ii) a preferred provider prepayment;

(iii) group practice;

(iv) individual practice plan; or

(v) health care insurance;

(c) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(d) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(e) coverage by Medicare or other governmental benefit.

(12) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

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

(14) "Insurer" means:

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

(b) a health maintenance organization; or

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

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

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

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

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

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

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

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

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

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

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

(ii) for religious or educational purposes.

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

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

31A-30-103. Definitions.

As used in this chapter:

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

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

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

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

(a) until January 1, 2012:

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

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

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

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

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

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

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

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

(b) "Case characteristics" do not include:

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

(ii) claim experience; and

(iii) health status.

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

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

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

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

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

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

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

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

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

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

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

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

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

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

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a

carrier's health benefit products that are individual policies.

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

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

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

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

(b) A covered carrier may not have:

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

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

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

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

(a) is not renewable; and

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

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

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

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

(25) "Uninsurable" means an individual who:

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

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

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

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

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

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

Section 18. Section **31A-30-104** is amended to read:

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employers; or

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

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

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

(a) whether the contract is issued to:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

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

(3) This chapter does not apply to:

[~~(a) a large employer health benefit plan, except as specifically provided in Part 2,~~

~~Defined Contribution Arrangements;~~]

[~~(b)~~] (a) short-term limited duration health insurance; or

[~~(c)~~] (b) federally funded or partially funded programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) a small employer carrier;

(b) a small employer carrier's agent;

(c) an insurance producer; and

(d) an insurance consultant.

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

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

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

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

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

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

the following:

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

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

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

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

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

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

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

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

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

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

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

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

(i) the following age bands:

(A) less than 20;

(B) 20-24;

(C) 25-29;

(D) 30-34;

(E) 35-39;

(F) 40-44;

(G) 45-49;

(H) 50-54;

(I) 55-59;

(J) 60-64; and

(K) 65 and above; and

(ii) a standard slope ratio range for each age band, applied to each family composition tier rating structure under Subsection (6)(c):

(A) as developed by the department by administrative rule;

(B) not to exceed an overall ratio of 5:1; and

(C) the age slope ratios for each age band may not overlap;

(b) geographic area; [~~and~~]

(c) family composition, limited to:

(i) an overall ratio of 5:1 or less; and

(ii) a four tier rating structure that includes:

(A) employee only;

(B) employee plus spouse;

(C) employee plus a dependent or dependents; and

(D) a family, consisting of an employee plus spouse, and a dependent or dependents; and

(d) gender of the employee or spouse.

(7) If a health benefit plan is a health benefit plan into which the small employer carrier is no longer enrolling new covered insureds, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the small employer carrier is actively enrolling new covered insureds.

(8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of

a class of business.

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

(i) case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

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

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

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

(A) the small employer carrier is in compliance with this chapter; and

(B) the rating methods of the small employer carrier are actuarially sound.

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

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

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

(i) implement this chapter; and

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

(b) The rules may:

(i) assure that differences in rates charged for health benefit plans by carriers are

reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans; and

(ii) prescribe the manner in which case characteristics may be used by small employer and individual carriers.

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

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

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

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

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

(ii) to determine if the rates are in compliance with Subsection 31A-30-202.5(1)(b);

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

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

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

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

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

(ii) paid by all small employer carriers participating in the defined contribution arrangement market and small employer carriers offering health benefit plans under Chapter 30, Part 1, Individual and Small Employer Group.

(c) The department shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) a defined benefit plan.

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

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

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

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

(b) A participating insurer may:

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

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

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

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

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

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

(a) one health benefit plan that:

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

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

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

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

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

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

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

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

(c) one health benefit plan that:

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

(ii) has a deductible that is within [~~$250~~] $1,000 of the highest deductible that qualifies as a federally qualified high deductible health plan, as adjusted by federal law[~~, and does not~~

~~exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible~~]; and

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

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

(i) include:

(A) the provider panel;

(B) the deductible;

(C) co-payments;

(D) co-insurance; and

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

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

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

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

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

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

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

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

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

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

31A-30-207. Rating and underwriting restrictions for health plans in the defined

contribution arrangement market.

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

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

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

(b) provide the risk adjuster board with:

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

(ii) carrier enrollment data; and

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

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

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

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

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

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

(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer group selecting a defined contribution arrangement health benefit plan on or before January 1, 2012; and

[~~(c) shall offer a limited pilot program in which a large employer group may enroll in a defined contribution arrangement market plan that takes effect January 1, 2011;~~]

[~~(d) beginning January 1, 2012, shall allow a large employer group to enroll in the defined contribution arrangement market; and~~]

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

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

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

(i) on January 1 of each year;

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

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

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

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

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

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

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

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

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

(b) is an appointed agent in accordance with Subsection (3), for products offered in the defined contribution arrangement market of the Health Insurance Exchange, with the [~~majority of the~~] carriers that offer a defined contribution arrangement health benefit plan on the Health Insurance Exchange; and

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

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

(ii) provides training on premium assistance programs.

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

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

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

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

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

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

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

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

31A-30-211. Insurer disclosure.

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

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

(b) the renewal of a health benefit plan.

(2) For health benefit plans that renew on or after March 1, 2012:

(a) a carrier in the small employer market under Part 1, Individual and Small Employer Group, shall provide an employer and the employer's producer with premium renewal rates at least 60 days prior to the group's renewal date; and

(b) the Health Insurance Exchange shall provide an employer who is participating in the defined contribution arrangement market of the Health Insurance Exchange and the employer's producer with premium renewal rates at least 60 days prior to a group's renewal.

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

31A-42-202. Contents of plan.

(1) The board shall submit a plan of operation for the risk adjuster to the commissioner. The plan shall:

(a) establish the methodology for implementing:

(i) Subsection (2) for the defined contribution arrangement market established under Chapter 30, Part 2, Defined Contribution Arrangements; and

(ii) the participation of[~~: (A)~~] small employer group defined contribution arrangement health benefit plans; [~~and~~]

[~~(B) large employer group defined contribution arrangement health benefit plans;~~]

(b) establish regular times and places for meetings of the board;

(c) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(d) contain additional provisions necessary and proper for the execution of the powers and duties of the risk adjuster; and

(e) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred.

(2) (a) The plan adopted by the board for the defined contribution arrangement market shall include:

(i) parameters an employer may use to designate eligible employees for the defined contribution arrangement market; and

(ii) underwriting mechanisms and employer eligibility guidelines:

(A) consistent with the federal Health Insurance Portability and Accountability Act; and

(B) necessary to protect insurance carriers from adverse selection in the defined contribution market.

(b) The plan required by Subsection (2)(a) shall outline how premium rates for a qualified individual are determined, including:

(i) the identification of an initial rate for a qualified individual based on:

(A) standardized age bands submitted by participating insurers; and

(B) wellness incentives for the individual as permitted by federal law; and

(ii) the identification of a group risk factor to be applied to the initial age rate of a qualified individual based on the health conditions of all qualified individuals in the same employer group and, for small employers, in accordance with Sections 31A-30-105 and 31A-30-106.1.

(c) The plan adopted under Subsection (2)(a) shall outline how:

(i) premium contributions for qualified individuals shall be submitted to the Health Insurance Exchange in the amount determined under Subsection (2)(b); and

(ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by qualified individuals within an employer group based on each individual's rating factor determined in accordance with the plan.

(d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting risk between insurers that:

(i) identifies health care conditions subject to risk adjustment;

(ii) establishes an adjustment amount for each identified health care condition;

(iii) determines the extent to which an insurer has more or less individuals with an identified health condition than would be expected; and

(iv) computes all risk adjustments.

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

[~~(i) incorporate large group defined contribution arrangement health benefit plans into the defined contribution arrangement market risk adjuster mechanism created by this chapter;~~]

[~~(ii)~~] (i) maintain the proper functioning and solvency of the defined contribution arrangement market and the risk adjuster mechanism;

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

[~~(iv)~~] (iii) improve the administration of the risk adjuster mechanism [~~including opening enrollment periodically until January 1, 2011, for the purpose of testing the enrollment and risk adjusting process~~].

(3) [~~(a)~~] The board shall establish a mechanism in which the participating carriers shall submit their plan base rates, rating factors, and premiums to [~~an independent actuary, appointed by the board, for review prior to the publication of the premium rates on the Health Insurance Exchange~~] the commissioner for an actuarial review under the provisions of Section 31A-30-115 prior to the publication of the premium rates on the Health Insurance Exchange.

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

[~~(i) be compensated for the analysis under this section from fees established in accordance with Section 63J-1-504:~~]

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

[~~(B) paid by all small employer carriers participating in the defined contribution arrangement market and small employer carriers offering health benefit plans under Chapter 30, Part 1, Individual and Small Employer Group; and~~]

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

[~~(A) under Subsection (3)(a) for the purpose of verifying the validity of the rates, rating factors, and premiums; and~~]

[~~(B) from carriers offering health benefit plans under Chapter 30, Part 1, Individual and Small Employer Group:~~]

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

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

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

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

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

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

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

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

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

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

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

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

(1) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The division shall adopt administrative rules:

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

(ii) in coordination with:

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

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

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

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

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

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

(iii) which establish:

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

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

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

(Aa) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

(I) an actuary; or

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

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

(iii) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (3)(g).

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

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

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

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

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

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

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

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

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

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section

34A-2-104 who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

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

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules

adopted by the division under Subsection (6).

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the executive director compliance with this section which shall include:

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

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

(I) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

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

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

Section 30. Section **63I-1-231** is amended to read:

63I-1-231. Repeal dates, Title 31A.

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.

(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.

(3) Section 31A-22-625, Catastrophic coverage of mental health conditions, is repealed July 1, 2011.

[~~(4) Chapter 42a, Utah Statewide Risk Adjuster Act, is repealed July 1, 2016.~~]

Section 31. Section **63J-1-602.2** is amended to read:

63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.

(1) Appropriations from the Technology Development Restricted Account created in Section 31A-3-104.

(2) Appropriations from the Criminal Background Check Restricted Account created in Section 31A-3-105.

(3) Appropriations from the Captive Insurance Restricted Account created in Section 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that section free revenue.

(4) Appropriations from the Title Licensee Enforcement Restricted Account created in Section 31A-23a-415.

(5) The fund for operating the state's Federal Health Care Tax Credit Program, as provided in Section 31A-38-104.

(6) Appropriations from the Health Insurance Actuarial Review Restricted Account created in Section 31A-30-115.

[~~(6)~~] (7) The Special Administrative Expense Account created in Section 35A-4-506.

[~~(7)~~] (8) Funding for a new program or agency that is designated as nonlapsing under Section 36-24-101.

[~~(8)~~] (9) The Oil and Gas Conservation Account created in Section 40-6-14.5.

[~~(9)~~] (10) The Off-Highway Access and Education Restricted Account created in Section 41-22-19.5.

Section 32. Section **63M-1-2504** is amended to read:

63M-1-2504. Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:

[~~(i) is capable of providing access to private and government health insurance websites and their electronic application forms and submission procedures;~~]

(i) provides information to consumers about private and public health programs for which the consumer may qualify;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange [~~by an insurer for the:~~]; and

[~~(A) small employer group market;~~]

[~~(B) the individual market; and~~]

[~~(C) the defined contribution arrangement market; and~~]

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) [~~facilitate a private sector method~~] contract with one or more private vendors for:

(i) administration of the enrollment process on the Health Insurance Exchange, including establishing a mechanism for consumers to compare health benefit plan features on the exchange and filter the plans based on consumer preferences;

(ii) the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others [~~by educating employers and insurers about collection services available through private vendors, including financial institutions~~]; and

(iii) establishing a call center in accordance with Subsection (3);

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars;

[~~(d) periodically convene health care providers, payers, and consumers to monitor the progress being made regarding demonstration projects for health care delivery and payment reform;~~]

[~~(c)~~] (d) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the [~~defined contribution arrangement market on the~~] Health Insurance Exchange; and

[~~(f)~~] (e) report to the Business and Labor Interim Committee and the Health System Reform Task Force prior to November 1, [~~2010~~] 2011, and prior to the Legislative interim day in November of each year thereafter regarding[~~: (i)~~] the operations of the Health Insurance Exchange required by this chapter[~~; and~~].

[~~(ii) the progress of the demonstration projects for health care payment and delivery reform.~~]

(3) A call center established by the office:

(a) shall provide unbiased answers to questions concerning exchange operations, and plan information, to the extent the plan information is posted on the exchange by the insurer; and

(b) may not:

(i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

(ii) beginning July 1, 2011, receive producer compensation through the Health Insurance Exchange; and

(iii) beginning July 1, 2011, be designated as the default producer for an employer group that enters the Health Insurance Exchange without a producer.

[~~(3)~~] (4) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, [~~or~~] health insurance producers, or health insurance premiums charged in the exchange;

(ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

(iii) act as an appeals entity for resolving disputes between a health insurer and an

insured; [~~and~~]

(b) may establish and collect a fee in accordance with Section 63J-1-504 for:

(i) the transaction cost of:

[~~(i)~~] (A) processing an application for a health benefit plan [~~from the Internet portal to an insurer; and~~];

[~~(ii)~~] (B) accepting, processing, and submitting multiple premium payment sources[~~.~~]; and

(C) providing a mechanism for consumers to filter and compare health benefit plans in the exchange based on consumer preferences; and

(ii) funding the call center established in accordance with Subsection (3); and

(c) shall separately itemize any fees established under Subsection (4)(b) as part of the cost displayed for the employer selecting coverage on the exchange.

Section 33. Section **63M-1-2506** is amended to read:

63M-1-2506. Health benefit plan information on Health Insurance Exchange -- Insurer transparency.

(1) (a) The office shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, [~~that:~~] that establish uniform electronic standards for insurers, employers, brokers, consumers, and vendors to use when transmitting or receiving information, uniform applications, waivers of coverage, or payments to, or from, the Health Insurance Exchange.

[~~(i) establish uniform electronic standards for:~~]

[~~(A) a health insurer to use when:~~]

[~~(I) transmitting information to:~~]

[~~(Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and~~]

[~~(Bb) the Health Insurance Exchange as required by this section;~~]

[~~(II) receiving information from the Health Insurance Exchange;~~]

[~~(III) receiving or transmitting the universal health application to or from the Health Insurance Exchange;~~]

[~~(B) facilitating the transmission and receipt of premium payments from multiple sources in the defined contribution arrangement market; and~~]

[~~(C) the use of the uniform health insurance application required by Section~~

~~31A-22-635 on the Health Insurance Exchange;~~]

[~~(ii) designate the level of detail that would be helpful for a concise consumer comparison of the items described in Subsections (4) and (5) on the Health Insurance Exchange;~~]

(b) The administrative rules adopted by the office shall:

(i) promote an efficient and consumer friendly process for shopping for and enrolling in a health benefit plan offered on the Health Insurance Exchange; and

(ii) if appropriate, as determined by the office, comply with standards adopted at the national level.

[~~(iii)~~] (2) The office shall assist the risk adjuster board created under Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on the Health Insurance Exchange with the determination of when an employer is eligible to participate in the Health Insurance Exchange under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements[~~, and~~].

[~~(iv)~~] (3) (a) The office shall create an advisory board to advise the exchange concerning the operation of the exchange, the consumer experience on the exchange, and transparency issues [~~with~~].

(b) The advisory board shall have the following members:

[~~(A)~~] (i) two health producers who are [~~registered~~] appointed producers with the Health Insurance Exchange;

[~~(B) two consumers;~~]

[~~(C) one representative from a large insurer who participates on the exchange;~~]

[~~(D) one representative from a small insurer who participates on the exchange;~~]

(ii) two representatives from community-based, non-profit organizations;

(iii) one representative from an employer that participates in the defined contribution market on the Health Insurance Exchange;

(iv) up to four representatives from insurers who participate in the defined contribution market of the Health Insurance Exchange;

[~~(E)~~] (v) one representative from the Insurance Department; and

[~~(F)~~] (vi) one representative from the Department of Health.

(c) Members of the advisory board shall serve without compensation.

[~~(b)~~] (4) The office shall post or facilitate the posting, on the Health Insurance Exchange, of[~~: (i)~~] the information required by this section [~~on the Health Insurance Exchange created by this part; and (ii)~~] and Section 31A-22-635 and links to websites that provide cost and quality information from the Department of Health Data Committee or neutral entities with a broad base of support from the provider and payer communities.

[~~(2) A health insurer shall use the uniform electronic standards when transmitting information to the Health Insurance Exchange or receiving information from the Health Insurance Exchange.~~]

[~~(3) (a) (i) An insurer who participates in the defined contribution arrangement market under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans offered in the defined contribution arrangement market on the Health Insurance Exchange and shall comply with the provisions of this section.~~]

[~~(ii) Beginning January 1, 2013, an insurer who offers a health benefit plan to a small employer group in the state shall:~~]

[~~(A) post the health benefit plans in which the insurer is enrolling new groups on the Health Insurance Exchange; and~~]

[~~(B) comply with the provisions of this section.~~]

[~~(b) An insurer who offers individual health benefit plans under Title 31A, Chapter 30, Part 1, Individual and Small Employer Group:~~]

[~~(i) shall post on the Health Insurance Exchange the basic benefit plan required by Section 31A-22-613.5; and~~]

[~~(ii) may publish on the Health Insurance Exchange any other health benefit plans that it offers in the individual market.~~]

[~~(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:~~]

[~~(i) shall comply with the provisions of this section for every health benefit plan it posts on the Health Insurance Exchange; and~~]

[~~(ii) may not offer products on the Health Insurance Exchange that are not health benefit plans.~~]

[~~(4) A health insurer shall provide the Health Insurance Exchange with the following information for each health benefit plan submitted to the Health Insurance Exchange:~~]

[~~(a) plan design, benefits, and options offered by the health benefit plan including state~~

~~mandates the plan does not cover;~~]

[~~(b) provider networks;~~]

[~~(c) wellness programs and incentives; and~~]

[~~(d) descriptions of prescription drug benefits, exclusions, or limitations.~~]

[~~(5) (a) An insurer offering any health benefit plan in the state shall submit the information described in Subsection (5)(b) to the Insurance Department in the electronic format required by Subsection (1).~~]

[~~(b) An insurer who offers a health benefit plan in the state shall submit to the Health Insurance Exchange the following operational measures:~~]

[~~(i) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer for the prior year; and~~]

[~~(ii) for all health benefit plans offered by the insurer in the state, the claims denial and insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).~~]

[~~(c) The Insurance Department shall forward to the Health Insurance Exchange the information submitted by an insurer in accordance with this section and Section 31A-22-613.5.~~]

[~~(6) The Insurance Department shall post on the Health Insurance Exchange the Insurance Department's solvency rating for each insurer who posts a health benefit plan on the Health Insurance Exchange. The solvency rating for each carrier shall be based on methodology established by the Insurance Department by administrative rule and shall be updated each calendar year.~~]

[~~(7) The commissioner may request information from an insurer under Section 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health Insurance Exchange under this section.~~]

[~~(8) A health insurer shall accept and process an application for a health benefit plan from the Health Insurance Exchange in accordance with this section and Section 31A-22-635.~~]

Section 34. Section **72-6-107.5** is amended to read:

72-6-107.5. Construction of improvements of highway -- Contracts -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section

34A-2-104 who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) This section does not apply if:

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

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

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) which establish:

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

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

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

(I) the Utah Insurance Department;

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

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

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

(A) a three-month suspension of the contractor or subcontractor from entering into

future contracts with the state upon the first violation;

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

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

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

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

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

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

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

(I) an actuary; or

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

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

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

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

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

(a) may not be the basis for a protest or other action from a prospective bidder, offeror,

or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

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

Section 35. Section **79-2-404** is amended to read:

79-2-404. Contracting powers of department -- Health insurance coverage.

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

[~~(II) dental coverage is not required; and~~]

[~~(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or~~]

[~~(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a deductible that is either:~~]

[~~(I) the lowest deductible permitted for a federally qualified high deductible health plan; or~~]

[~~(II) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;~~]

[~~(B) an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and~~]

[~~(C) under which the employer pays 75% of the premium for the employee and the dependents of the employee who work or reside in the state.~~]

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) (a) Except as provided in Subsection (3), this section applies a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, and to a prime contractor or to a subcontractor in accordance with Subsection (2)(b).

(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $1,500,000 or greater.

(ii) A subcontractor is subject to this section if a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply to contracts entered into by the department or a division, board, or council of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division, board, or council of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor shall demonstrate to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) a public transit district in accordance with Section 17B-2a-818.5;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate compliance with this section to the department which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required for qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

(II) an actuary selected by the contractor or the contractor's insurer; or

(III) an underwriter who is responsible for developing the employer group's premium rates;

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6-804 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the benchmark for the qualified

health insurance coverage identified in Subsection (1)(c)[~~(i)~~].

(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by:

(I) an actuary; or

(II) an underwriter who is responsible for developing the employer group's premium rates; or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, Legal and Contractual Remedies; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 36. **Repealer.**

This bill repeals:

Section **31A-42a-101 (Effective 01/01/13), Title.**

Section **31A-42a-102 (Effective 01/01/13), Definitions.**

Section **31A-42a-201 (Effective 01/01/13), Creation of defined contribution market**

risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

Section **31A-42a-202 (Effective 01/01/13), Contents of plan.**

Section **31A-42a-203 (Effective 01/01/13), Powers and duties of board.**

Section **31A-42a-204 (Effective 01/01/13), Powers of commissioner.**

Section 37. **Health System Reform Task Force -- Creation -- Membership -- Interim rules followed -- Compensation -- Staff.**

(1) There is created the Health System Reform Task Force consisting of the following 11 members:

(a) four members of the Senate appointed by the president of the Senate, no more than three of whom may be from the same political party; and

(b) seven members of the House of Representatives appointed by the speaker of the House of Representatives, no more than five of whom may be from the same political party.

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a cochair of the committee.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a cochair of the committee.

(3) In conducting its business, the committee shall comply with the rules of legislative interim committees.

(4) Salaries and expenses of the members of the committee shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override Sessions.

(5) The Office of Legislative Research and General Counsel shall provide staff support to the committee.

Section 38. **Duties -- Interim report.**

(1) The task force shall review and make recommendations on the following issues:

(a) the state's response to federal health care reform, including whether the state should develop an American Health Benefit Exchange under the federal Affordable Care Act for individual health benefit plans, individual premium assistance, tax credits, and Medicaid eligibility determinations;

(b) legislation necessary to implement:

(i) the governance structure for the Health Insurance Exchange to:

(A) preserve the market-based defined contribution model for employers in the Health Insurance Exchange;

(B) provide better control of state expenditures on health care for state employees, retirees and their families;

(C) incentives to improve health among state employees; and

(D) position Utah to continue with a market based, consumer driven insurance exchange;

(ii) an operational blue print for the Health Insurance Exchange to promote an appropriate balance between private sector solutions and efficiencies for the exchange and state regulatory functions related to insurance market conduct; and

(iii) funding requirements associated with the governance structure and better use of the Public Employees' Benefit and Insurance Program assets and competencies;

(c) which market regulatory functions should be given to the Health Insurance Exchange and which should remain with the Insurance Department, the Department of Health, or the Department of Workforce Services;

(d) policy and guidance regarding the state's implementation of the small group defined contribution arrangement market on the Health Insurance Exchange, including the consumer experience and information on the exchange concerning cost, quality, and transparency;

(e) whether the risk adjuster mechanism in the exchange should be modified;

(f) health care cost containment issues, including:

(i) progress on the demonstration projects and grants that involve health care providers and payers to provide systemwide aligned incentives for the appropriate delivery of, and payment for, health care; and

(ii) effective tools for reducing the cost or perceived costs of medical malpractice liability in the health care system; and

(g) the appropriate balance of cost and benefits provided by insurance plans available on the exchange, including possible consideration of spiritual care, vision care, and dental services.

(2) The task force shall coordinate with the Legislative Retirement and Independent

Entities Interim Committee when it studies and makes recommendations regarding operational functions of the Health Insurance Exchange as it relates to state expenditures for health insurance for public employees, retirees and their families.

(3) A final report, including any proposed legislation shall be presented to the Health and Human Services Interim Committee before November 30, 2011.

Section 39. **Intent language regarding lapsing of money.**

It is the intent of the Legislature that money received by the Insurance Department during fiscal year 2010-11 under Section 31A-30-115 shall be considered dedicated credits and in closing out the fiscal year 2010-11 the unspent dedicated credits shall lapse to the Health Insurance Actuarial Review Restricted Account.

Section 40. **Repeal date.**

(1) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Sections 48 and 49, which enacted the 2010 Health System Reform Task Force.

(2) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Section 50, Subsection (3), which provided a future effective date of January 1, 2013, for Title 31A, Chapter 42a, Utah Statewide Risk Adjuster Act.

(3) The Health System Reform Task Force created in Sections 34 and 35 of this bill is repealed on December 30, 2011.