

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;



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

57 ▶ provides intent language that fees received by the Insurance Department in 2010, for
58 the department's actuarial review as dedicated credits, shall lapse to the Health
59 Insurance Actuarial Review Restricted Account;

60 ▶ repeals the statewide risk adjuster mechanism that was effective January 1, 2013;
61 and

62 ▶ makes technical and conforming amendments.

63 **Money Appropriated in this Bill:**

64 None

65 **Other Special Clauses:**

66 This bill provides a repeal date for certain provisions.

67 **Utah Code Sections Affected:**

68 AMENDS:

69 **17B-2a-818.5**, as last amended by Laws of Utah 2010, Chapter 229

70 **19-1-206**, as last amended by Laws of Utah 2010, Chapters 218 and 229

71 **26-33a-102**, as last amended by Laws of Utah 1996, Chapter 232

72 **26-33a-103**, as last amended by Laws of Utah 2010, Chapter 286

73 **26-33a-106.5**, as last amended by Laws of Utah 2005, Chapter 266

74 **26-40-106**, as last amended by Laws of Utah 2007, Chapter 47

75 **31A-2-212**, as last amended by Laws of Utah 2007, Chapter 309

76 **31A-22-613.5**, as last amended by Laws of Utah 2010, Chapters 68, 149 and last
77 amended by Coordination Clause, Laws of Utah 2010, Chapter 149

78 **31A-22-614.6**, as last amended by Laws of Utah 2010, Chapter 68

79 **31A-22-625**, as last amended by Laws of Utah 2010, Chapters 10 and 68

80 **31A-22-635**, as last amended by Laws of Utah 2010, Chapter 68

81 **31A-22-724**, as enacted by Laws of Utah 2009, Chapter 12

82 **31A-29-103**, as last amended by Laws of Utah 2008, Chapters 3 and 385

83 **31A-30-103**, as last amended by Laws of Utah 2010, Chapter 68

84 **31A-30-104**, as last amended by Laws of Utah 2009, Chapter 12

85 **31A-30-106.1**, as enacted by Laws of Utah 2010, Chapter 68

86 **31A-30-203**, as last amended by Laws of Utah 2010, Chapter 68

87 **31A-30-205**, as last amended by Laws of Utah 2010, Chapters 68, 149 and last

88 amended by Coordination Clause, Laws of Utah 2010, Chapter 149
89 **31A-30-207**, as last amended by Laws of Utah 2010, Chapter 68
90 **31A-30-208**, as repealed and reenacted by Laws of Utah 2010, Chapter 68
91 **31A-30-209**, as enacted by Laws of Utah 2010, Chapter 68
92 **31A-42-202**, as last amended by Laws of Utah 2010, Chapter 68
93 **63A-5-205**, as last amended by Laws of Utah 2010, Chapter 229
94 **63C-9-403**, as last amended by Laws of Utah 2010, Chapter 229
95 **63I-1-231**, as last amended by Laws of Utah 2010, Chapters 68 and 319
96 **63J-1-602.2**, as enacted by Laws of Utah 2010, Chapter 265 and last amended by
97 Coordination Clause, Laws of Utah 2010, Chapter 265
98 **63M-1-2504**, as last amended by Laws of Utah 2010, Chapter 68
99 **63M-1-2506**, as last amended by Laws of Utah 2010, Chapter 68
100 **72-6-107.5**, as last amended by Laws of Utah 2010, Chapter 229
101 **79-2-404**, as last amended by Laws of Utah 2010, Chapter 229

102 ENACTS:

103 **26-1-39**, Utah Code Annotated 1953
104 **26-40-115**, Utah Code Annotated 1953
105 **31A-23a-115.5**, Utah Code Annotated 1953
106 **31A-30-115**, Utah Code Annotated 1953
107 **31A-30-211**, Utah Code Annotated 1953

108 REPEALS:

109 **31A-42a-101 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
110 **31A-42a-102 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
111 **31A-42a-201 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
112 **31A-42a-202 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
113 **31A-42a-203 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68
114 **31A-42a-204 (Effective 01/01/13)**, as enacted by Laws of Utah 2010, Chapter 68

115 **Uncodified Material Affected:**

116 ENACTS UNCODIFIED MATERIAL

117 REPEALS UNCODIFIED MATERIAL:

118 **Laws of Utah 2010, Chapter 68, Uncodified Section 48**

119 **Laws of Utah 2010, Chapter 68, Uncodified Section 49**

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



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

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

124 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**
125 **coverage.**

126 (1) For purposes of this section:

127 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
128 34A-2-104 who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

169 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
170 \$750,000 or greater.

171 (3) This section does not apply if:

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

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

174 (c) the contract is an emergency procurement.

175 (4) (a) This section does not apply to a change order as defined in Section ~~[63G-6-102]~~
176 63G-6-103, or a modification to a contract, when the contract does not meet the initial
177 threshold required by Subsection (2).

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

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

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

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

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

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

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

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

198 (6) The public transit district shall adopt ordinances:

199 (a) in coordination with:

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

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

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

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

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

205 (b) which establish:

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

208 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

209 (b) more than twice in any 12-month period; and

210 (B) that the actuarially equivalent determination required for the qualified health

211 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the

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

213 (I) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

239 (I) actuary; or

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

241 or

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

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

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

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

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

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

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

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

257 **19-1-206. Contracting powers of department -- Health insurance coverage.**

258 (1) For purposes of this section:

259 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
260 34A-2-104 who:

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

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

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

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

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

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

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

275 ~~[(F) rather than the benchmark plan's deductible, and the benchmark plan's~~

276 ~~out-of-pocket maximum based on income levels:]~~

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

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

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

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

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

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

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

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

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

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

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

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

302 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
303 \$750,000 or greater.

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

305 or board of the department if:

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

307 (b) the contract or agreement is between:

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

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

310 (B) the federal government;

311 (C) another state;

312 (D) an interstate agency;

313 (E) a political subdivision of this state; or

314 (F) a political subdivision of another state;

315 (c) the executive director determines that applying the requirements of this section to a

316 particular contract interferes with the effective response to an immediate health and safety

317 threat from the environment; or

318 (d) the contract is:

319 (i) a sole source contract; or

320 (ii) an emergency procurement.

321 (4) (a) This section does not apply to a change order as defined in Section 63G-6-103,

322 or a modification to a contract, when the contract does not meet the initial threshold required

323 by Subsection (2).

324 (b) A person who intentionally uses change orders or contract modifications to

325 circumvent the requirements of Subsection (2) is guilty of an infraction.

326 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive

327 director that the contractor has and will maintain an offer of qualified health insurance

328 coverage for the contractor's employees and the employees' dependents during the duration of

329 the contract.

330 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall

331 demonstrate to the executive director that the subcontractor has and will maintain an offer of

332 qualified health insurance coverage for the subcontractor's employees and the employees'

333 dependents during the duration of the contract.

334 (c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration

335 of the contract is subject to penalties in accordance with administrative rules adopted by the

336 department under Subsection (6).

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

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

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

344 (6) The department shall adopt administrative rules:

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

346 (b) in coordination with:

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

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

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

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

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

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

353 (c) which establish:

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

356 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

357 (b) more than twice in any 12-month period; and

358 (B) that the actuarially equivalent determination required for the qualified health

359 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
360 department or division with a written statement of actuarial equivalency from either:

361 (I) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

387 (I) an actuary; or

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

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

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

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

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

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

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

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

405 **26-1-39. Health System Reform Demonstration Projects.**

406 The department may coordinate with the Insurance Department and periodically
407 convene health care providers, payers, and consumers, who elect to participate in a
408 demonstration project under Section 31A-22-614.6, to monitor the progress being made
409 regarding demonstration projects for health care delivery and payment reform under Section
410 31A-22-614.6.

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

412 **26-33a-102. Definitions.**

413 As used in this chapter:

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

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

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

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

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

424 (6) "Health care facility" means a facility that is licensed by the department under Title
425 26, Chapter 21, Health Care Facility [~~Licensure~~] Licensing and Inspection Act. The committee
426 may by rule add, delete, or modify the list of facilities that come within this definition for
427 purposes of this chapter.

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

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

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

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

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

445 (11) "Individual" means a natural person.

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

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

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

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

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

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

455 and

456 (e) preparing and publishing reports describing these matters.

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

460 payments.

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

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

464 (a) an insurer offering a health ~~[care insurance]~~ benefit plan, as defined by Section
465 31A-1-301, ~~[any]~~ to at least 2,500 enrollees in the state;

466 (b) a nonprofit health service insurance corporation licensed under Title 31A, Chapter
467 7, Nonprofit Health Service Insurance Corporations~~[, any]~~;

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

471 (d) a corporation, organization, association, entity, or person~~[-]~~;

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

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

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

478 **26-33a-103. Committee membership -- Terms -- Chair -- Compensation.**

479 (1) The Health Data Committee created by Section 26-1-7 shall be composed of ~~[13]~~
480 14 members appointed by the governor with the consent of the Senate.

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

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

486 (4) The membership of the committee shall be:

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

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

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

493 (ii) who actively practice medicine in this state;

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

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

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

499 ~~[(d)] (c) three persons;~~

500 (i) who are:

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

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

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

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

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

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

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

514 ~~[(f)] (e) two consumer representatives;~~

515 (i) from organized consumer or employee associations; and

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

517 ~~[(g)] (f) one person [broadly];~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

550 (a) Section 63A-3-106;

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

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

553 63A-3-107.

554 (11) All meetings of the committee shall be open to the public, except that the
555 committee may hold a closed meeting if the requirements of Sections 52-4-204, 52-4-205, and
556 52-4-206 are met.

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

558 **26-33a-106.5. Comparative analyses.**

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

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

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

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

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

568 (i) be published at least annually; and

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

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

571 (B) charges; and

572 (C) nationally recognized patient safety standards.

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

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

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

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

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

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

590 (i) routine and preventive care; and

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

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

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

599 (i) results for health care facilities or institutions;

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

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

605 (d) The department:

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

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

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

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

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

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

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

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

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

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

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

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

637 **26-40-106. Program benefits.**

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

- 640 (a) hospital services;
- 641 (b) physician services;
- 642 (c) laboratory services;
- 643 (d) prescription drugs;
- 644 (e) mental health services;
- 645 (f) basic dental services;

646 (g) preventive care including:

647 (i) routine physical examinations;

648 (ii) immunizations;

649 (iii) basic vision services; and

650 (iv) basic hearing services;

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

652 (i) hospice care.

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

657 (b) Except as provided in Subsection (2)(~~e~~)(d), after July 1, 2008:

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

659 and

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

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

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

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

669 **26-40-115. State contractor -- Employee and dependent health benefit plan**
670 **coverage.**

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

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

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

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

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

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

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

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

686 (ii) dental coverage is not required; and

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

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

690 (a) has a deductible that is either:

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

692 or

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

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

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

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

703 **31A-2-212. Miscellaneous duties.**

704 (1) Upon issuance of any order limiting, suspending, or revoking an insurer's authority
705 to do business in Utah, and on institution of any proceedings against the insurer under Chapter
706 27a, Insurer Receivership Act, the commissioner:

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

708 and

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

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

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

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

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

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

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

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

730 (A) files a petition for receivership; or

731 (B) is in receivership; or

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

734 (A) is in financial difficulty; or

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

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

739 with a new surety.

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

742 (a) the Health Insurance Portability and Accountability Act, [~~P.L. 104-191~~] Pub. L. No.
743 104-191, pursuant to 110 Stat. 1968, Sec. 2722[-]; and

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

748 (i) lifetime and annual limits;

749 (ii) prohibition of rescissions;

750 (iii) coverage of preventive health services;

751 (iv) coverage for a child or dependent;

752 (v) pre-existing condition coverage for children;

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

755 (vii) premium rate reviews;

756 (viii) essential benefits;

757 (ix) provider choice;

758 (x) waiting periods; and

759 (xi) appeals processes.

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

761 **31A-22-613.5. Price and value comparisons of health insurance.**

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

763 (b) Subsection (2) applies to:

764 (i) all health benefit plans; and

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

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

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

- 770 (A) restrictions or limitations on prescription drugs and biologics including:
- 771 (I) the use of a formulary;
- 772 (II) co-payments and deductibles for prescription drugs; and
- 773 (III) requirements for generic substitution;
- 774 (B) coverage limits under the plan; and
- 775 (C) any limitation or exclusion of coverage including:
- 776 (I) a limitation or exclusion for a secondary medical condition related to a limitation or
- 777 exclusion from coverage; and
- 778 (II) easily understood examples of a limitation or exclusion of coverage for a secondary
- 779 medical condition; and
- 780 (ii) provide the commissioner with:
- 781 (A) the information described in Subsections [~~63M-1-2506(3) through (6)~~
- 782 31A-22-635(5) through (7) in the standardized electronic format required by Subsection
- 783 63M-1-2506(1); and
- 784 (B) information regarding insurer transparency in accordance with Subsection [~~(5)~~] (4).
- 785 (b) An insurer shall provide the disclosure required by Subsection (2)(a)(i) in writing to
- 786 the commissioner:
- 787 (i) upon commencement of operations in the state; and
- 788 (ii) anytime the insurer amends any of the following described in Subsection (2)(a)(i):
- 789 (A) treatment policies;
- 790 (B) practice standards;
- 791 (C) restrictions;
- 792 (D) coverage limits of the insurer's health benefit plan or health insurance policy; or
- 793 (E) limitations or exclusions of coverage including a limitation or exclusion for a
- 794 secondary medical condition related to a limitation or exclusion of the insurer's health
- 795 insurance plan.
- 796 (c) An insurer shall provide the enrollee with notice of an increase in costs for
- 797 prescription drug coverage due to a change in benefit design under Subsection (2)(a)(i)(A):
- 798 (i) either:
- 799 (A) in writing; or
- 800 (B) on the insurer's website; and

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

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

805 (i) the drugs included;

806 (ii) the patented drugs not included;

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

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

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

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

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

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

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

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

826 ~~[(4)]~~ (3) The commissioner:

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

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

831 ~~[(5)]~~ (4) The commissioner shall:

832 (a) convene a group of insurers, a member representing the Public Employees' Benefit
833 and Insurance Program, consumers, and an organization described in Subsection
834 31A-22-614.6(3)(b), to develop information for consumers to compare health insurers and
835 health benefit plans on the Health Insurance Exchange, which shall include consideration of:
836 (i) the number and cost of an insurer's denied health claims;
837 (ii) the cost of denied claims that is transferred to providers;
838 (iii) the average out-of-pocket expenses incurred by participants in each health benefit
839 plan that is offered by an insurer in the Health Insurance Exchange;
840 (iv) the relative efficiency and quality of claims administration and other administrative
841 processes for each insurer offering plans in the Health Insurance Exchange; and
842 (v) consumer assessment of each insurer or health benefit plan;
843 (b) adopt an administrative rule that establishes:
844 (i) definition of terms;
845 (ii) the methodology for determining and comparing the insurer transparency
846 information;
847 (iii) the data, and format of the data, that an insurer must submit to the [department]
848 commissioner in order to facilitate the consumer comparison on the Health Insurance Exchange
849 in accordance with Section 63M-1-2506; and
850 (iv) the dates on which the insurer must submit the data to the [department]
851 commissioner in order for the [department] commissioner to transmit the data to the Health
852 Insurance Exchange in accordance with Section 63M-1-2506; and
853 (c) implement the rules adopted under Subsection [~~5~~] (4)(b) in a manner that protects
854 the business confidentiality of the insurer.

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

856 **31A-22-614.6. Health care delivery and payment reform demonstration projects.**

857 (1) The Legislature finds that:

858 (a) current health care delivery and payment systems do not provide systemwide
859 aligned incentives for the appropriate delivery of health care;
860 (b) some health care providers and health care payers have developed ideas for health
861 care delivery and payment system reform, but lack the critical number of patient lives and
862 payer involvement to accomplish systemwide reform; and

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

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

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

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

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

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

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

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

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

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

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

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

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

898 **31A-22-625. Catastrophic coverage of mental health conditions.**

899 (1) As used in this section:

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

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

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

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

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

917 (A) episodic limits;

918 (B) inpatient or outpatient service limits; or

919 (C) maximum out-of-pocket limits.

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

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

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

925 primary or substantial reason or need for treatment:

926 (A) a marital or family problem;

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

928 (C) a conduct disorder;

929 (D) a chronic adjustment disorder;

930 (E) a psychosexual disorder;

931 (F) a chronic organic brain syndrome;

932 (G) a personality disorder;

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

934 (I) mental retardation.

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

936 (2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer

937 that it insures or seeks to insure a choice between:

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

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

940 (ii) 50/50 mental health coverage.

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

942 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels

943 that exceed the minimum requirements of this section; or

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

945 (c) A small employer may, at its option, regardless of the employer's previous coverage

946 for mental health conditions, choose either [~~catastrophic mental health coverage, 50/50 mental~~

947 ~~health coverage, or~~];

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

949 (ii) 50/50 mental health coverage; or

950 (iii) coverage offered under Subsection (2)(b)[~~, regardless of the employer's previous~~

951 ~~coverage for mental health conditions]~~.

952 (d) An insurer is exempt from the 30% index rating restriction in Section

953 31A-30-106.1 and, for the first year only that catastrophic mental health coverage is chosen, the

954 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or

955 less enrolled employees who chooses coverage that meets or exceeds catastrophic mental

956 health coverage.

957 (3) An insurer shall offer a large employer mental health and substance use disorder
958 benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec.
959 300gg-5, and federal regulations adopted pursuant to that act.

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

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

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

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

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

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

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

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

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

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

982 (ii) in a health care facility:

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

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

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

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

987 written plan.

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

990 (6) The commissioner shall:

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

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

994 (i) no mental health coverage;

995 (ii) 50/50 mental health coverage;

996 (iii) catastrophic mental health coverage; and

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

998 (7) This section may not be construed as discouraging or otherwise preventing an
999 insurer from providing mental health coverage in connection with an individual insurance
1000 policy.

1001 (8) This section shall be repealed in accordance with Section 63I-1-231.

1002 Section 13. Section **31A-22-635** is amended to read:

1003 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**
1004 **on Health Insurance Exchange.**

1005 (1) For purposes of this section, "insurer":

1006 (a) is defined in Subsection 31A-22-634(1); and

1007 (b) includes the state employee's risk pool under Section 49-20-202.

1008 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall[:
1009 ~~(i) except as provided in Subsection (6);~~] use a uniform application form[~~;~~ ~~which, beginning~~
1010 ~~October 1, 2010;~~].

1011 (b) The uniform application form:

1012 [~~(A)~~] (i) except for cancer and transplants, may not include questions about an
1013 applicant's health history prior to the previous [~~+0~~] five years; and

1014 [~~(B)~~] (ii) shall be shortened and simplified in accordance with rules adopted by the
1015 [~~department; and~~] commissioner.

1016 [~~(ii)~~] (c) Insurers offering a health benefit plan to a small employer shall use a uniform
1017 waiver of coverage form, which[~~;~~ ~~(A)~~] may not include health status related questions other

1018 than pregnancy[;], and ~~[(B)]~~ is limited to:

1019 ~~[(F)]~~ (i) information that identifies the employee;

1020 ~~[(H)]~~ (ii) proof of the employee's insurance coverage; and

1021 ~~[(HH)]~~ (iii) a statement that the employee declines coverage with a particular employer
1022 group.

1023 ~~[(b)]~~ (3) Notwithstanding the requirements of Subsection (2)(a), the uniform
1024 application and uniform waiver of coverage forms may be combined or modified to facilitate[;]
1025 a more efficient and consumer friendly experience for enrollees using the Health Insurance
1026 Exchange if the modification is approved by the commissioner.

1027 ~~[(i) the electronic submission and processing of an application through the Health~~
1028 ~~Insurance Exchange created pursuant to Section 63M-1-2504 or directly to all carriers; and]~~

1029 ~~[(ii) a more efficient and understandable experience for a consumer submitting an~~
1030 ~~application in the Health Insurance Exchange or directly to all carriers.]~~

1031 ~~[(3) An insurer offering a defined contribution arrangement health benefit plan in the~~
1032 ~~Health Insurance Exchange to a large group shall use a large group uniform application, and~~
1033 ~~uniform waiver of coverage form, that is adopted by the department by administrative rule.]~~

1034 (4) ~~[(a)-(i)]~~ The uniform application form, and uniform waiver form, shall be adopted
1035 and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah
1036 Administrative Rulemaking Act.

1037 ~~[(ii) Modifications to the uniform application necessary to facilitate the electronic~~
1038 ~~submission and processing of an application through the Health Insurance Exchange shall be~~
1039 ~~adopted by administrative rule adopted by the Office of Consumer Health Services in~~
1040 ~~accordance with Section 63M-1-2506.]~~

1041 ~~[(b) The commissioner shall convene the health insurance industry, the Office of~~
1042 ~~Consumer Health Services, and consumers to review the uniform application for the individual~~
1043 ~~and small group market, and the large group market, and make recommendations regarding the~~
1044 ~~uniform applications. The department shall report the findings of the group convened pursuant~~
1045 ~~to this Subsection (4)(b) to the Legislature no later than July 1, 2010.]~~

1046 (5) (a) ~~[Beginning October 1, 2010, an]~~ An insurer who offers a health benefit plan in
1047 either the group or individual market on the Health Insurance Exchange created in Section
1048 63M-1-2504, shall:

1049 (i) accept and process an electronic submission of the uniform application or uniform
1050 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
1051 Section 63M-1-2506; [~~and~~]

1052 (ii) if requested, provide the applicant with a copy of the completed application either
1053 by mail or electronically[-];

1054 (iii) post all health benefit plans offered by the insurer in the defined contribution
1055 arrangement market on the Health Insurance Exchange; and

1056 (iv) post the information required by Subsection (6) on the Health Insurance Exchange
1057 for every health benefit plan the insurer offers on the Health Insurance Exchange.

1058 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans
1059 on the Health Insurance Exchange may not directly or indirectly offer products on the Health
1060 Insurance Exchange that are not health benefit plans.

1061 (c) Notwithstanding Subsection (5)(b), an insurer may offer a health savings account
1062 on the Health Insurance Exchange.

1063 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with
1064 the following information for each health benefit plan submitted to the Health Insurance
1065 Exchange, in the electronic format required by Subsection 63M-1-2506(1):

1066 (a) plan design, benefits, and options offered by the health benefit plan including state
1067 mandates the plan does not cover;

1068 (b) information and Internet address to online provider networks;

1069 (c) wellness programs and incentives;

1070 (d) descriptions of prescription drug benefits, exclusions, or limitations;

1071 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is
1072 submitted to the insurer for the prior year; and

1073 (f) the claims denial and insurer transparency information developed in accordance
1074 with Subsection 31A-22-613.5(4).

1075 (7) The Insurance Department shall post on the Health Insurance Exchange the
1076 Insurance Department's solvency rating for each insurer who posts a health benefit plan on the
1077 Health Insurance Exchange. The solvency rating for each insurer shall be based on
1078 methodology established by the Insurance Department by administrative rule and shall be
1079 updated each calendar year.

1080 (8) (a) The commissioner may request information from an insurer under Section
1081 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health
1082 Insurance Exchange.

1083 (b) The commissioner shall regulate any fees charged by insurers to an enrollee for a
1084 uniform application form or electronic submission of the application forms.

1085 ~~[(6) An insurer offering a health benefit plan outside the Health Insurance Exchange~~
1086 ~~may use the uniform application in effect prior to May 15, 2010, until January 1, 2011.]~~

1087 Section 14. Section **31A-22-724** is amended to read:

1088 **31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**

1089 (1) For purposes of this section, "alternative coverage" means:

1090 (a) ~~[the]~~ a high deductible or low deductible Utah NetCare Plan described in
1091 Subsection (2) for a conversion ~~[policies]~~ health benefit plan policy offered under Section
1092 31A-22-723; and

1093 (b) ~~[the]~~ a high deductible and low deductible Utah NetCare Plans described in
1094 Subsection (2) as an alternative to COBRA and mini-COBRA ~~[policies]~~ health benefit plan
1095 coverage offered under Section 31A-22-722.

1096 (2) ~~[The]~~ A Utah NetCare ~~[Plans]~~ Plan under this section is subject to Section
1097 31A-2-212 and shall, except when prohibited by federal law, include:

1098 (a) healthy lifestyle and wellness incentives;

1099 (b) the benefits described in this Subsection (2) or at least the actuarial equivalent of
1100 the benefits described in this Subsection (2);

1101 (c) a lifetime maximum benefit per person of not less than \$1,000,000;

1102 (d) an annual maximum benefit per person of not less than \$250,000;

1103 (e) the following deductibles:

1104 (i) for ~~[the]~~ a low deductible ~~[plans]~~ plan:

1105 (A) \$2,000 for an individual plan;

1106 (B) \$4,000 for a two party plan; and

1107 (C) \$6,000 for a family plan;

1108 (ii) for ~~[the]~~ a high deductible ~~[plans]~~ plan:

1109 (A) \$4,000 for an individual plan;

1110 (B) \$8,000 for a two party plan; and

- 1111 (C) \$12,000 for a family plan;
- 1112 (f) the following out-of-pocket maximum costs, including deductibles, copayments,
- 1113 and coinsurance:
- 1114 (i) for ~~[the]~~ a low deductible ~~[plans]~~ plan:
- 1115 (A) \$5,000 for an individual plan;
- 1116 (B) \$10,000 for a two party plan; and
- 1117 (C) \$15,000 for a family plan; and
- 1118 (ii) for ~~[the]~~ a high deductible plan:
- 1119 (A) \$10,000 for an individual plan;
- 1120 (B) \$20,000 for a two party plan; and
- 1121 (C) \$30,000 for a family plan;
- 1122 (g) the following benefits before applying ~~[any]~~ a deductible ~~[requirements]~~
- 1123 requirement and in accordance with ~~[IRC]~~ Section 223, Internal Revenue Code, and 42 U.S.C.
- 1124 Sec. 300gg-13:
- 1125 (i) all well child exams and immunizations up to age five, with no annual maximum;
- 1126 (ii) preventive care up to a \$500 annual maximum;
- 1127 (iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i)
- 1128 or (ii) up to a \$300 annual maximum; and
- 1129 (iv) supplemental accident coverage up to a \$500 annual maximum;
- 1130 (h) the following copayments for each exam:
- 1131 (i) \$15 for preventive care and well child exams;
- 1132 (ii) \$25 for primary care; and
- 1133 (iii) \$50 for urgent care and specialist care;
- 1134 (i) a \$200 copayment for an emergency room ~~[visits]~~ visit after applying the
- 1135 deductible;
- 1136 (j) no more than a 30% coinsurance after deductible for covered plan benefits for:
- 1137 (i) hospital services~~[-]~~;
- 1138 (ii) maternity~~[-]~~;
- 1139 (iii) laboratory work~~[-]~~;
- 1140 (iv) x-rays~~[-]~~;
- 1141 (v) radiology~~[-]~~;

- 1142 (vi) outpatient surgery services[;];
- 1143 (vii) injectable medications not otherwise covered under a pharmacy benefit[;];
- 1144 (viii) durable medical equipment[;];
- 1145 (ix) ambulance services[;];
- 1146 (x) in-patient mental health services[;]; and
- 1147 (xi) out-patient mental health services; and
- 1148 (k) the following cost-sharing features for a prescription [~~drugs~~] drug:
- 1149 (i) up to a \$15 copayment for a generic [~~drugs;~~] drug; and
- 1150 (ii) up to a 50% coinsurance for a name brand [~~drugs; and~~] drug.
- 1151 [~~(iii) may include formularies and preferred drug lists.~~]
- 1152 (3) [~~The~~] A Utah NetCare [~~Plans~~] Plan may exclude:
- 1153 (a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)(b); and
- 1154 (b) unless required by federal law, mandated coverage required by the following
- 1155 sections and related administrative rules:
- 1156 (i) Section 31A-22-610.1, Adoption indemnity [~~benefits~~] benefit;
- 1157 (ii) Section 31A-22-623, Coverage of inborn metabolic errors;
- 1158 (iii) Section 31A-22-624, Primary care [~~physicians~~] physician;
- 1159 (iv) Section 31A-22-626, Coverage of diabetes;
- 1160 (v) Section 31A-22-628, Standing referral to a specialist; and
- 1161 (vi) [~~coverage mandates~~] a mandated coverage enacted after January 1, 2009, that [~~are~~]
- 1162 is not required by federal law.
- 1163 [~~(4)(a) Beginning January 1, 2010, and except~~]
- 1164 (4) A Utah NetCare Plan may include a formulary or preferred drug list.
- 1165 (5)(a) Except as provided in Subsection [~~(5)~~] (6), a person may elect alternative
- 1166 coverage under this section if the person is eligible for:
- 1167 (i) [~~is eligible for~~] continuation of employer group health benefit plan coverage under
- 1168 federal COBRA laws;
- 1169 (ii) [~~is eligible for~~] continuation of employer group health benefit plan coverage under
- 1170 state mini-COBRA under Section 31A-22-722; or
- 1171 (iii) [~~is eligible for~~] a conversion to an individual health benefit plan after the
- 1172 exhaustion of benefits under:

1173 (A) alternative coverage elected in place of federal COBRA; or

1174 (B) state mini-COBRA under Section 31A-22-722.

1175 (b) The right to extend coverage under Subsection ~~[(4)]~~ (5)(a) applies to ~~[any]~~ spouse
1176 or dependent coverages, including a surviving spouse or dependent whose coverage under the
1177 policy terminates by reason of the death of the employee or member.

1178 ~~[(5)]~~ (6) If a person elects federal COBRA ~~[coverage,]~~ or state mini-COBRA health
1179 benefit plan coverage under Section 31A-22-722, the person is not eligible to elect alternative
1180 coverage under this section until the person is eligible to convert coverage to an individual
1181 policy under ~~[the provisions of]~~ Section 31A-22-723 and Subsection (1)(a).

1182 ~~[(6)]~~ (7) (a) (i) If ~~[the]~~ alternative coverage is selected as an alternative to COBRA or
1183 mini-COBRA health benefit plan coverage under Section 31A-22-722, ~~[the provisions of]~~
1184 Section 31A-22-722 ~~[apply]~~ applies to the alternative coverage.

1185 (ii) If an employee of a small employer selects alternative coverage as an alternative to
1186 COBRA or mini-COBRA health benefit plan coverage, the insurer may not use a risk factor
1187 greater than the employer's most current risk factor for purposes of Subsection 31A-22-722(5).

1188 (b) If ~~[the]~~ alternative coverage is selected as a conversion policy under Section
1189 31A-22-723, ~~[the provisions of]~~ Section 31A-22-723 ~~[apply]~~ applies.

1190 ~~[(7) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall, prior to~~
1191 ~~September 1, 2009, file an alternative coverage policy with the department in accordance with~~
1192 ~~Sections 31A-21-201 and 31A-21-201.1.]~~

1193 ~~[(b)]~~ (8) The ~~[department]~~ commissioner shall~~[-, by November 1, 2009,]~~ adopt
1194 administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
1195 Act, to develop a model letter for employers to use to notify an employee of the employee's
1196 options for alternative coverage.

1197 Section 15. Section **31A-23a-115.5** is enacted to read:

1198 **31A-23a-115.5. Use of customer service representative.**

1199 A customer service representative licensed under this chapter:

1200 (1) may not maintain an office independent of the customer service representative's
1201 licensed producer or consultant employer for the purpose of conducting insurance activities;

1202 (2) except as provided in Subsection (3), may not sell, solicit, negotiate, or bind
1203 coverage; and

1204 (3) may provide a customer a quote on behalf of the customer service representative's
1205 licensed producer or consultant employer.

1206 Section 16. Section **31A-29-103** is amended to read:

1207 **31A-29-103. Definitions.**

1208 As used in this chapter:

1209 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.

1210 (2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

1211 (b) "Creditable coverage" does not include a period of time in which there is a

1212 significant break in coverage, as defined in Section 31A-1-301.

1213 (3) "Domicile" means the place where an individual has a fixed and permanent home
1214 and principal establishment:

1215 (a) to which the individual, if absent, intends to return; and

1216 (b) in which the individual, and the individual's family voluntarily reside, not for a
1217 special or temporary purpose, but with the intention of making a permanent home.

1218 (4) "Enrollee" means an individual who has met the eligibility requirements of the pool
1219 and is covered by a pool policy under this chapter.

1220 (5) "Health benefit plan":

1221 (a) is defined in Section 31A-1-301; and

1222 (b) does not include a plan that:

1223 (i) (A) has a maximum actuarial value less ~~[that]~~ than 100% of ~~[the basic health care~~

1224 ~~plan; or]~~ a health benefit plan described in Subsection (5)(c); or

1225 (B) has a maximum annual limit of \$100,000 or less; and

1226 (ii) meets other criteria established by the board.

1227 (c) For purposes of Subsection (5)(b)(i)(A) the health benefit plan shall:

1228 (i) be a federally qualified high deductible health plan;

1229 (ii) have a deductible that has the lowest deductible that qualifies as a federally

1230 qualified high deductible health plan as adjusted by federal law; and

1231 (iii) not exceed an annual out-of-pocket maximum equal to three times the amount of
1232 the deductible.

1233 (6) "Health care facility" means any entity providing health care services which is

1234 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

- 1235 (7) "Health care insurance" is defined in Section 31A-1-301.
- 1236 (8) "Health care provider" has the same meaning as provided in Section 78B-3-403.
- 1237 (9) "Health care services" means:
- 1238 (a) any service or product:
- 1239 (i) used in furnishing to any individual medical care or hospitalization; or
- 1240 (ii) incidental to furnishing medical care or hospitalization; and
- 1241 (b) any other service or product furnished for the purpose of preventing, alleviating,
- 1242 curing, or healing human illness or injury.
- 1243 (10) "Health maintenance organization" has the same meaning as provided in Section
- 1244 31A-8-101.
- 1245 (11) "Health plan" means any arrangement by which an individual, including a
- 1246 dependent or spouse, covered or making application to be covered under the pool has:
- 1247 (a) access to hospital and medical benefits or reimbursement including group or
- 1248 individual insurance or subscriber contract;
- 1249 (b) coverage through:
- 1250 (i) a health maintenance organization;
- 1251 (ii) a preferred provider prepayment;
- 1252 (iii) group practice;
- 1253 (iv) individual practice plan; or
- 1254 (v) health care insurance;
- 1255 (c) coverage under an uninsured arrangement of group or group-type contracts
- 1256 including employer self-insured, cost-plus, or other benefits methodologies not involving
- 1257 insurance;
- 1258 (d) coverage under a group type contract which is not available to the general public
- 1259 and can be obtained only because of connection with a particular organization or group; and
- 1260 (e) coverage by Medicare or other governmental benefit.
- 1261 (12) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996,
- 1262 Pub. L. 104-191, 110 Stat. 1936.
- 1263 (13) "HIPAA eligible" means an individual who is eligible under the provisions of the
- 1264 Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.
- 1265 (14) "Insurer" means:

1266 (a) an insurance company authorized to transact accident and health insurance business
1267 in this state;

1268 (b) a health maintenance organization; or

1269 (c) a self-insurer not subject to federal preemption.

1270 (15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.
1271 Sec. 1396 et seq., as amended.

1272 (16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social
1273 Security Act, 42 U.S.C. 1395 et seq., as amended.

1274 (17) "Plan of operation" means the plan developed by the board in accordance with
1275 Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board
1276 under Section 31A-29-106.

1277 (18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section
1278 31A-29-104.

1279 (19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund
1280 created in Section 31A-29-120.

1281 (20) "Pool policy" means a health benefit plan policy issued under this chapter.

1282 (21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

1283 (22) (a) "Resident" or "residency" means a person who is domiciled in this state.

1284 (b) A resident retains residency if that resident leaves this state:

1285 (i) to serve in the armed forces of the United States; or

1286 (ii) for religious or educational purposes.

1287 (23) "Third party administrator" has the same meaning as provided in Section
1288 31A-1-301.

1289 Section 17. Section **31A-30-103** is amended to read:

1290 **31A-30-103. Definitions.**

1291 As used in this chapter:

1292 (1) "Actuarial certification" means a written statement by a member of the American
1293 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
1294 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,
1295 including review of the appropriate records and of the actuarial assumptions and methods used
1296 by the covered carrier in establishing premium rates for applicable health benefit plans.

1297 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
1298 through one or more intermediaries, controls or is controlled by, or is under common control
1299 with, a specified entity or person.

1300 (3) "Base premium rate" means, for each class of business as to a rating period, the
1301 lowest premium rate charged or that could have been charged under a rating system for that
1302 class of business by the covered carrier to covered insureds with similar case characteristics for
1303 health benefit plans with the same or similar coverage.

1304 (4) "Basic benefit plan" or "basic coverage" means ~~[the coverage provided in the Basic~~
1305 ~~Health Care Plan under Section 31A-22-613.5.]~~ a health benefit plan that:

1306 (a) until January 1, 2012:

1307 (i) is a federally qualified high deductible health plan;

1308 (ii) has a deductible that has the lowest deductible that qualifies as a federally qualified
1309 high deductible health plan as adjusted by federal law; and

1310 (iii) does not exceed an annual out-of-pocket maximum equal to three times the
1311 amount of the deductible; and

1312 (b) on or after January 1, 2012, is actuarially equivalent to the NetCare plan with the
1313 highest actuarial value, as provided in Section 31A-22-724.

1314 (5) "Carrier" means any person or entity that provides health insurance in this state
1315 including:

1316 (a) an insurance company;

1317 (b) a prepaid hospital or medical care plan;

1318 (c) a health maintenance organization;

1319 (d) a multiple employer welfare arrangement; and

1320 (e) any other person or entity providing a health insurance plan under this title.

1321 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
1322 demographic or other objective characteristics of a covered insured that are considered by the
1323 carrier in determining premium rates for the covered insured.

1324 (b) "Case characteristics" do not include:

1325 (i) duration of coverage since the policy was issued;

1326 (ii) claim experience; and

1327 (iii) health status.

1328 (7) "Class of business" means all or a separate grouping of covered insureds that is
1329 permitted by the department in accordance with Section 31A-30-105.

1330 (8) "Conversion policy" means a policy providing coverage under the conversion
1331 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

1332 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
1333 this chapter.

1334 (10) "Covered individual" means any individual who is covered under a health benefit
1335 plan subject to this chapter.

1336 (11) "Covered insureds" means small employers and individuals who are issued a
1337 health benefit plan that is subject to this chapter.

1338 (12) "Dependent" means an individual to the extent that the individual is defined to be
1339 a dependent by:

1340 (a) the health benefit plan covering the covered individual; and

1341 (b) Chapter 22, Part 6, Accident and Health Insurance.

1342 (13) "Established geographic service area" means a geographical area approved by the
1343 commissioner within which the carrier is authorized to provide coverage.

1344 (14) "Index rate" means, for each class of business as to a rating period for covered
1345 insureds with similar case characteristics, the arithmetic average of the applicable base
1346 premium rate and the corresponding highest premium rate.

1347 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
1348 through a health benefit plan regardless of whether:

1349 (a) coverage is offered through:

1350 (i) an association;

1351 (ii) a trust;

1352 (iii) a discretionary group; or

1353 (iv) other similar groups; or

1354 (b) the policy or contract is situated out-of-state.

1355 (16) "Individual conversion policy" means a conversion policy issued to:

1356 (a) an individual; or

1357 (b) an individual with a family.

1358 (17) "Individual coverage count" means the number of natural persons covered under a

1359 carrier's health benefit products that are individual policies.

1360 (18) "Individual enrollment cap" means the percentage set by the commissioner in
1361 accordance with Section 31A-30-110.

1362 (19) "New business premium rate" means, for each class of business as to a rating
1363 period, the lowest premium rate charged or offered, or that could have been charged or offered,
1364 by the carrier to covered insureds with similar case characteristics for newly issued health
1365 benefit plans with the same or similar coverage.

1366 (20) "Premium" means all money paid by covered insureds and covered individuals as
1367 a condition of receiving coverage from a covered carrier, including any fees or other
1368 contributions associated with the health benefit plan.

1369 (21) (a) "Rating period" means the calendar period for which premium rates
1370 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1371 (b) A covered carrier may not have:

1372 (i) more than one rating period in any calendar month; and

1373 (ii) no more than 12 rating periods in any calendar year.

1374 (22) "Resident" means an individual who has resided in this state for at least 12
1375 consecutive months immediately preceding the date of application.

1376 (23) "Short-term limited duration insurance" means a health benefit product that:

1377 (a) is not renewable; and

1378 (b) has an expiration date specified in the contract that is less than 364 days after the
1379 date the plan became effective.

1380 (24) "Small employer carrier" means a carrier that provides health benefit plans
1381 covering eligible employees of one or more small employers in this state, regardless of
1382 whether:

1383 (a) coverage is offered through:

1384 (i) an association;

1385 (ii) a trust;

1386 (iii) a discretionary group; or

1387 (iv) other similar grouping; or

1388 (b) the policy or contract is situated out-of-state.

1389 (25) "Uninsurable" means an individual who:

1390 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
1391 underwriting criteria established in Subsection 31A-29-111(5); or
1392 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
1393 (ii) has a condition of health that does not meet consistently applied underwriting
1394 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)
1395 and (j) for which coverage the applicant is applying.

1396 (26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
1397 purposes of this formula:

1398 (a) "CI" means the carrier's individual coverage count as of December 31 of the
1399 preceding year; and

1400 (b) "UC" means the number of uninsurable individuals who were issued an individual
1401 policy on or after July 1, 1997.

1402 Section 18. Section **31A-30-104** is amended to read:

1403 **31A-30-104. Applicability and scope.**

1404 (1) This chapter applies to any:

1405 (a) health benefit plan that provides coverage to:

1406 (i) individuals;

1407 (ii) small employers; or

1408 (iii) both Subsections (1)(a)(i) and (ii); or

1409 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
1410 31A-30-107.5.

1411 (2) This chapter applies to a health benefit plan that provides coverage to small
1412 employers or individuals regardless of:

1413 (a) whether the contract is issued to:

1414 (i) an association;

1415 (ii) a trust;

1416 (iii) a discretionary group; or

1417 (iv) other similar grouping; or

1418 (b) the situs of delivery of the policy or contract.

1419 (3) This chapter does not apply to:

1420 [~~(a) a large employer health benefit plan, except as specifically provided in Part 2,~~

1421 ~~Defined Contribution Arrangements;~~

1422 [~~(b)~~] (a) short-term limited duration health insurance; or

1423 [~~(c)~~] (b) federally funded or partially funded programs.

1424 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:

1425 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
1426 return shall be treated as one carrier; and

1427 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
1428 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
1429 carriers were issued by one carrier.

1430 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
1431 maintenance organization having a certificate of authority under this title may be considered to
1432 be a separate carrier for the purposes of this chapter.

1433 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
1434 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
1435 arrangements with respect to health benefit plans delivered or issued for delivery to covered
1436 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
1437 obligation or risk for the health benefit plans being retained by the ceding carrier.

1438 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
1439 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
1440 for delivery to covered insureds in this state.

1441 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
1442 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
1443 may make a written request to the commissioner for a waiver from the application of any of the
1444 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
1445 trust.

1446 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
1447 waiver if the commissioner finds that application with respect to the trust would:

1448 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
1449 and

1450 (ii) require significant modifications to one or more collective bargaining arrangements
1451 under which the trust is established or maintained.

1452 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
1453 person participates in a Taft Hartley trust as an associate member of any employee
1454 organization.

1455 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
1456 31A-30-111 apply to:

1457 (a) any insurer engaging in the business of insurance related to the risk of a small
1458 employer for medical, surgical, hospital, or ancillary health care expenses of the small
1459 employer's employees provided as an employee benefit; and

1460 (b) any contract of an insurer, other than a workers' compensation policy, related to the
1461 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the
1462 small employer's employees provided as an employee benefit.

1463 (7) The commissioner may make rules requiring that the marketing practices be
1464 consistent with this chapter for:

1465 (a) a small employer carrier;

1466 (b) a small employer carrier's agent;

1467 (c) an insurance producer; and

1468 (d) an insurance consultant.

1469 Section 19. Section **31A-30-106.1** is amended to read:

1470 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

1471 (1) Premium rates for small employer health benefit plans under this chapter are
1472 subject to the provisions of this section for a health benefit plan that is issued or renewed, on or
1473 after ~~January 1~~ July 1, 2011.

1474 (2) (a) The index rate for a rating period for any class of business may not exceed the
1475 index rate for any other class of business by more than 20%.

1476 (b) For a class of business, the premium rates charged during a rating period to covered
1477 insureds with similar case characteristics for the same or similar coverage, or the rates that
1478 could be charged to an employer group under the rating system for that class of business, may
1479 not vary from the index rate by more than 30% of the index rate, except when catastrophic
1480 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

1481 (3) The percentage increase in the premium rate charged to a covered insured for a new
1482 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of

1483 the following:

1484 (a) the percentage change in the new business premium rate measured from the first
1485 day of the prior rating period to the first day of the new rating period;

1486 (b) any adjustment, not to exceed 15% annually for rating periods of less than one year,
1487 due to the claim experience, health status, or duration of coverage of the covered individuals as
1488 determined from the small employer carrier's rate manual for the class of business, except when
1489 catastrophic mental health coverage is selected as provided in Subsection 31A-22-625(2)(d);
1490 and

1491 (c) any adjustment due to change in coverage or change in the case characteristics of
1492 the covered insured as determined for the class of business from the small employer carrier's
1493 rate manual.

1494 (4) (a) Adjustments in rates for claims experience, health status, and duration from
1495 issue may not be charged to individual employees or dependents.

1496 (b) Rating adjustments and factors, including case characteristics, shall be applied
1497 uniformly and consistently to the rates charged for all employees and dependents of the small
1498 employer.

1499 (c) Rating factors shall produce premiums for identical groups that:

1500 (i) differ only by the amounts attributable to plan design; and

1501 (ii) do not reflect differences due to the nature of the groups assumed to select
1502 particular health benefit products.

1503 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the
1504 same calendar month as having the same rating period.

1505 (5) A health benefit plan that uses a restricted network provision may not be considered
1506 similar coverage to a health benefit plan that does not use a restricted network provision,
1507 provided that use of the restricted network provision results in substantial difference in claims
1508 costs.

1509 (6) The small employer carrier may not use case characteristics other than the
1510 following:

1511 (a) age, as determined at the beginning of the plan year, limited to:

1512 (i) the following age bands:

1513 (A) less than 20;

- 1514 (B) 20-24;
- 1515 (C) 25-29;
- 1516 (D) 30-34;
- 1517 (E) 35-39;
- 1518 (F) 40-44;
- 1519 (G) 45-49;
- 1520 (H) 50-54;
- 1521 (I) 55-59;
- 1522 (J) 60-64; and
- 1523 (K) 65 and above; and
- 1524 (ii) a standard slope ratio range for each age band, applied to each family composition
- 1525 tier rating structure under Subsection (6)(c):
- 1526 (A) as developed by the department by administrative rule;
- 1527 (B) not to exceed an overall ratio of 5:1; and
- 1528 (C) the age slope ratios for each age band may not overlap;
- 1529 (b) geographic area; [~~and~~]
- 1530 (c) family composition, limited to:
- 1531 (i) an overall ratio of 5:1 or less; and
- 1532 (ii) a four tier rating structure that includes:
- 1533 (A) employee only;
- 1534 (B) employee plus spouse;
- 1535 (C) employee plus a dependent or dependents; and
- 1536 (D) a family, consisting of an employee plus spouse, and a dependent or dependents;
- 1537 and
- 1538 (d) gender of the employee or spouse.
- 1539 (7) If a health benefit plan is a health benefit plan into which the small employer carrier
- 1540 is no longer enrolling new covered insureds, the small employer carrier shall use the percentage
- 1541 change in the base premium rate, provided that the change does not exceed, on a percentage
- 1542 basis, the change in the new business premium rate for the most similar health benefit product
- 1543 into which the small employer carrier is actively enrolling new covered insureds.
- 1544 (8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of

1545 a class of business.

1546 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
1547 of business unless the offer is made to transfer all covered insureds in the class of business
1548 without regard to:

- 1549 (i) case characteristics;
- 1550 (ii) claim experience;
- 1551 (iii) health status; or
- 1552 (iv) duration of coverage since issue.

1553 (9) (a) Each small employer carrier shall maintain at the small employer carrier's
1554 principal place of business a complete and detailed description of its rating practices and
1555 renewal underwriting practices, including information and documentation that demonstrate that
1556 the small employer carrier's rating methods and practices are:

- 1557 (i) based upon commonly accepted actuarial assumptions; and
- 1558 (ii) in accordance with sound actuarial principles.

1559 (b) (i) Each small employer carrier shall file with the commissioner on or before April
1560 1 of each year, in a form and manner and containing information as prescribed by the
1561 commissioner, an actuarial certification certifying that:

- 1562 (A) the small employer carrier is in compliance with this chapter; and
- 1563 (B) the rating methods of the small employer carrier are actuarially sound.
- 1564 (ii) A copy of the certification required by Subsection (9)(b)(i) shall be retained by the
1565 small employer carrier at the small employer carrier's principal place of business.

1566 (c) A small employer carrier shall make the information and documentation described
1567 in this Subsection (9) available to the commissioner upon request.

1568 (10) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with
1569 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

- 1570 (i) implement this chapter; and
- 1571 (ii) assure that rating practices used by small employer carriers under this section and
1572 carriers for individual plans under Section 31A-30-106, as effective on January 1, 2011, are
1573 consistent with the purposes of this chapter.

1574 (b) The rules may:

- 1575 (i) assure that differences in rates charged for health benefit plans by carriers are

1576 reasonable and reflect objective differences in plan design, not including differences due to the
1577 nature of the groups or individuals assumed to select particular health benefit plans; and

1578 (ii) prescribe the manner in which case characteristics may be used by small employer
1579 and individual carriers.

1580 (11) Records submitted to the commissioner under this section shall be maintained by
1581 the commissioner as protected records under Title 63G, Chapter 2, Government Records
1582 Access and Management Act.

1583 Section 20. Section **31A-30-115** is enacted to read:

1584 **31A-30-115. Actuarial review of health benefit plans.**

1585 (1) (a) The department shall conduct an actuarial review of rates submitted by small
1586 employer carriers:

1587 (i) prior to the publication of the premium rates on the Health Insurance Exchange;

1588 (ii) to determine if the rates are in compliance with Subsection 31A-30-202.5(1)(b);

1589 (iii) to verify the validity of the rates, underwriting and risk factors, and premiums of
1590 plans both in and outside of the Health Insurance Exchange;

1591 (iv) to verify that insurers are pricing similar health benefit plans and groups the same
1592 in and out of the exchange; and

1593 (v) as the department determines is necessary to oversee market conduct.

1594 (b) The actuarial review by the department shall be funded from a fee:

1595 (i) established by the department in accordance with Section 63J-1-504; and

1596 (ii) paid by all small employer carriers participating in the defined contribution
1597 arrangement market and small employer carriers offering health benefit plans under Chapter
1598 30, Part 1, Individual and Small Employer Group.

1599 (c) The department shall:

1600 (i) report aggregate data from the actuarial review to the risk adjuster board created in
1601 Section 31A-42-201; and

1602 (ii) contact carriers, if the department determines it is appropriate, to:

1603 (A) inform a carrier of the department's findings regarding the rates of a particular
1604 carrier; and

1605 (B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

1606 (d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

1607 (2) (a) There is created in the General Fund a restricted account known as the "Health
1608 Insurance Actuarial Review Restricted Account."

1609 (b) The Health Insurance Actuarial Review Restricted Account shall consist of money
1610 received by the commissioner under this section.

1611 (c) The commissioner shall administer the Health Insurance Actuarial Review
1612 Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use
1613 money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the
1614 actuarial review conducted by the department under this section.

1615 Section 21. Section **31A-30-203** is amended to read:

1616 **31A-30-203. Eligibility for defined contribution arrangement market --**

1617 **Enrollment.**

1618 (1) (a) An eligible small employer may choose to participate in:

1619 (i) the defined contribution arrangement market in the Health Insurance Exchange
1620 under this part; or

1621 (ii) the traditional defined benefit market under Part 1, Individual and Small Employer
1622 Group.

1623 (b) A small employer may choose to offer its employees one of the following through
1624 the defined contribution arrangement market in the Health Insurance Exchange:

1625 (i) a defined contribution arrangement health benefit plan; or

1626 (ii) a defined benefit plan.

1627 [~~(c) (i) Beginning January 1, 2011, and during the enrollment period, an eligible large~~
1628 ~~employer participating in the demonstration project under Subsection 31A-30-208(1)(c) may~~
1629 ~~choose to offer its employees a defined contribution arrangement health benefit plan.]~~

1630 [~~(ii) Beginning January 1, 2012, an eligible large employer may choose to offer its~~
1631 ~~employees a defined contribution arrangement health benefit plan.]~~

1632 [~~(d)~~] (c) Defined contribution arrangement health benefit plans are employer group
1633 health plans individually selected by an employee of an employer.

1634 (2) (a) Participating insurers shall offer to accept all eligible employees of an employer
1635 described in Subsection (1), and their dependents, at the same level of benefits as anyone else
1636 who has the same health benefit plan in the defined contribution arrangement market on the
1637 Health Insurance Exchange.

1638 (b) A participating insurer may:

1639 (i) request an employer to submit a copy of the employer's quarterly wage list to
1640 determine whether the employees for whom coverage is provided or requested are bona fide
1641 employees of the employer; and

1642 (ii) deny or terminate coverage if the employer refuses to provide documentation
1643 requested under Subsection (2)(b)(i).

1644 Section 22. Section **31A-30-205** is amended to read:

1645 **31A-30-205. Health benefit plans offered in the defined contribution market.**

1646 (1) An insurer who offers a defined contribution arrangement health benefit plan in the
1647 small group market shall offer the following health benefit plans as defined contribution
1648 arrangements:

1649 [~~(a) the basic benefit plan;~~]

1650 (a) one health benefit plan that:

1651 (i) is a federally qualified high deductible health plan;

1652 (ii) has a deductible that is within \$250 of the lowest deductible that qualifies as a
1653 federally qualified high deductible health plan as adjusted by federal law; and

1654 (iii) has an annual out-of-pocket maximum that does not exceed three times the amount
1655 of the deductible;

1656 [~~(b) one health benefit plan with an aggregate actuarial value at least 15% greater than~~
1657 ~~the actuarial value of the basic benefit plan;~~]

1658 [~~(c)~~] (b) [on or before January 1, 2011,] one health benefit plan that:

1659 (i) is a federally qualified high deductible health plan that [has] is within \$250 of an
1660 individual deductible of \$2,500 and a deductible of \$5,000 for coverage including two or more
1661 individuals[;]; and

1662 (ii) does not exceed an annual out-of-pocket maximum equal to three times the amount
1663 of the annual deductible;

1664 [~~(d) on or before January 1, 2011,]~~

1665 (c) one health benefit plan that:

1666 (i) is a federally qualified high deductible health plan [that];

1667 (ii) has a deductible that is within [~~\$250~~] \$1,000 of the highest deductible that qualifies
1668 as a federally qualified high deductible health plan, as adjusted by federal law[~~, and does not~~

1669 exceed an annual out-of-pocket maximum equal to three times the amount of the annual
1670 deductible]; and

1671 (iii) has an out-of-pocket maximum that qualifies as a federally qualified high
1672 deductible health plan;

1673 ~~[(e)]~~ (d) the insurer's ~~[five]~~ four most commonly selected small group health benefit
1674 plans that:

1675 (i) include:

1676 (A) the provider panel;

1677 (B) the deductible;

1678 (C) co-payments;

1679 (D) co-insurance; and

1680 (E) pharmacy benefits; ~~[and]~~

1681 (ii) are currently being marketed by the carrier to new groups for enrollment[-]; and

1682 (iii) meet the standard for most commonly selected plan as determined by

1683 administrative rule adopted by the commissioner; and

1684 (e) alternative coverage required by Section 31A-22-724.

1685 (2) (a) The provisions of Subsection (1) do not limit the number of defined
1686 contribution arrangement health benefit plans an insurer may offer in the defined contribution
1687 arrangement market.

1688 (b) An insurer who offers the health benefit plans required by Subsection (1) may also
1689 offer any other health benefit plan as a defined contribution arrangement if ~~[(i) the health~~
1690 ~~benefit plan provides benefits that are of greater actuarial value than the benefits required in the~~
1691 ~~basic benefit plan; or (ii)]~~ the health benefit plan provides benefits with an aggregate actuarial
1692 value that is no lower than the actuarial value of the plan required in Subsection (1)(c).

1693 (3) An employee who has the right to extend employer coverage under Subsection
1694 31A-22-722(1) or federal COBRA, may:

1695 (a) continue coverage under the employee's current plan under state mini-COBRA or
1696 federal COBRA; or

1697 (b) enroll in alternative coverage under Section 31A-22-724.

1698 Section 23. Section **31A-30-207** is amended to read:

1699 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**

1700 **contribution arrangement market.**

1701 (1) The rating and underwriting restrictions for defined benefit plans and for the
1702 defined contribution arrangement health benefit plans offered in the Health Insurance
1703 Exchange defined contribution arrangement market shall be[: (a) ~~for small employer groups;~~
1704 in accordance with Section 31A-30-106.1[: (b) ~~for large employer groups, as determined by~~
1705 ~~the risk adjuster board for participation in the risk adjustment mechanism under Chapter 42;~~
1706 ~~Defined Contribution Risk Adjuster Act; and (c) established in accordance with], and the plan
1707 adopted under Chapter 42, Defined Contribution Risk Adjuster Act.~~

1708 (2) All insurers who participate in the defined contribution market shall:

1709 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined
1710 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;

1711 (b) provide the risk adjuster board with:

1712 (i) an employer group's risk factor; and

1713 (ii) carrier enrollment data; and

1714 (c) submit rates to the exchange that are net of commissions.

1715 (3) When an employer group [~~of any size~~] enters the defined contribution arrangement
1716 market for either a defined contribution arrangement health benefit plan, or a defined benefit
1717 plan, and the employer group has a health plan with an insurer who is participating in the
1718 defined contribution arrangement market, the risk factor applied to the employer group when it
1719 enters the defined contribution market may not be greater than the employer group's renewal
1720 risk factor for the same group of covered employees and the same effective date, as determined
1721 by the employer group's insurer.

1722 Section 24. Section **31A-30-208** is amended to read:

1723 **31A-30-208. Enrollment for defined contribution arrangements.**

1724 (1) An insurer offering a health benefit plan in the defined contribution arrangement
1725 market:

1726 (a) [~~beginning on or after January 1, 2011;~~] shall allow an employer to enroll in a small
1727 employer defined contribution arrangement plan;

1728 (b) may not impose a surcharge under Section 31A-30-106.7 for a small employer
1729 group selecting a defined contribution arrangement health benefit plan on or before January 1,
1730 2012; and

1731 ~~[(e) shall offer a limited pilot program in which a large employer group may enroll in a~~
1732 ~~defined contribution arrangement market plan that takes effect January 1, 2011;]~~

1733 ~~[(d) beginning January 1, 2012, shall allow a large employer group to enroll in the~~
1734 ~~defined contribution arrangement market, and]~~

1735 ~~[(e)]~~ (c) shall otherwise comply with the requirements of this part, Chapter 42, Defined
1736 Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

1737 (2) (a) Except as provided in Subsection 31A-30-202.5(2), in accordance with
1738 Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined
1739 contribution arrangement market.

1740 (b) An insurer may offer new or modify existing products in the defined contribution
1741 arrangement market:

1742 (i) on January 1 of each year;

1743 (ii) when required by changes in other law; and

1744 (iii) at other times as established by the risk adjuster board created in Section
1745 31A-42-201.

1746 (c) (i) An insurer shall give the department, the Health Insurance Exchange, and the
1747 risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a)
1748 or (b).

1749 (ii) When an insurer elects to participate in the defined contribution arrangement
1750 market, the insurer shall participate in the defined contribution arrangement market for no less
1751 than two years.

1752 Section 25. Section **31A-30-209** is amended to read:

1753 **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**

1754 (1) A producer may be listed on the Health Insurance Exchange as a producer for the
1755 defined contribution arrangement market in accordance with Section 63M-1-2504, if the
1756 producer is designated as an appointed agent for the defined contribution arrangement market
1757 in accordance with Subsection (2).

1758 (2) A producer whose license under this title authorizes the producer to sell defined
1759 contribution arrangement health benefit plans may be appointed to the defined contribution
1760 arrangement market on the Health Insurance Exchange by the Insurance Department and may
1761 sell any product on the Health Insurance Exchange, if the producer:

1762 (a) submits an application to the Insurance Department to be appointed as a producer
1763 for the defined contribution arrangement market on the Health Insurance Exchange;

1764 (b) is an appointed agent in accordance with Subsection (3), for products offered in the
1765 defined contribution arrangement market of the Health Insurance Exchange, with the [majority
1766 ~~of the~~] carriers that offer a defined contribution arrangement health benefit plan on the Health
1767 Insurance Exchange; and

1768 (c) has completed [a] continuing education for the defined contribution arrangement
1769 ~~[training session that is an approved training session as designated by the commissioner.]~~
1770 market that:

1771 (i) is required by administrative rule adopted by the commissioner; and

1772 (ii) provides training on premium assistance programs.

1773 (3) A carrier shall appoint a producer to sell the carrier's products in the defined
1774 contribution arrangement market of the Health Insurance Exchange, within 30 days of the
1775 notice required in Subsection (3)(b), if:

1776 (a) the producer is currently appointed by a majority of the carriers in the Health
1777 Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange;
1778 and

1779 (b) the producer informs the carrier that the producer is:

1780 (i) applying to be appointed to the defined contribution arrangement market in the
1781 Health Insurance Exchange;

1782 (ii) appointed by a majority of the carriers in the defined contribution arrangement
1783 market in the Health Insurance Exchange;

1784 (iii) willing to complete training regarding the carrier's products offered on the defined
1785 contribution arrangement market in the Health Insurance Exchange; and

1786 (iv) willing to sign the contracts and business associate's agreements that the carrier
1787 requires for appointed producers in the Health Insurance Exchange.

1788 Section 26. Section **31A-30-211** is enacted to read:

1789 **31A-30-211. Insurer disclosure.**

1790 (1) The Health Insurance Exchange shall provide an employer and an employer's
1791 producer with the group's risk factor used to calculate the employer group's premium at the
1792 time of:

- 1793 (a) the initial offering of a health benefit plan; and
 1794 (b) the renewal of a health benefit plan.
 1795 (2) For health benefit plans that renew on or after March 1, 2012:
 1796 (a) a carrier in the small employer market under Part 1, Individual and Small Employer
 1797 Group, shall provide an employer and the employer's producer with premium renewal rates at
 1798 least 60 days prior to the group's renewal date; and
 1799 (b) the Health Insurance Exchange shall provide an employer who is participating in
 1800 the defined contribution arrangement market of the Health Insurance Exchange and the
 1801 employer's producer with premium renewal rates at least 60 days prior to a group's renewal.
- 1802 Section 27. Section **31A-42-202** is amended to read:
- 1803 **31A-42-202. Contents of plan.**
- 1804 (1) The board shall submit a plan of operation for the risk adjuster to the
 1805 commissioner. The plan shall:
- 1806 (a) establish the methodology for implementing:
- 1807 (i) Subsection (2) for the defined contribution arrangement market established under
 1808 Chapter 30, Part 2, Defined Contribution Arrangements; and
- 1809 (ii) the participation of~~[: (A)]~~ small employer group defined contribution arrangement
 1810 health benefit plans; ~~[and]~~
 1811 ~~[(B) large employer group defined contribution arrangement health benefit plans;]~~
- 1812 (b) establish regular times and places for meetings of the board;
- 1813 (c) establish procedures for keeping records of all financial transactions and for
 1814 sending annual fiscal reports to the commissioner;
- 1815 (d) contain additional provisions necessary and proper for the execution of the powers
 1816 and duties of the risk adjuster; and
- 1817 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
 1818 Code, to pay for administrative expenses incurred.
- 1819 (2) (a) The plan adopted by the board for the defined contribution arrangement market
 1820 shall include:
- 1821 (i) parameters an employer may use to designate eligible employees for the defined
 1822 contribution arrangement market; and
- 1823 (ii) underwriting mechanisms and employer eligibility guidelines:

1824 (A) consistent with the federal Health Insurance Portability and Accountability Act;
1825 and

1826 (B) necessary to protect insurance carriers from adverse selection in the defined
1827 contribution market.

1828 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
1829 qualified individual are determined, including:

1830 (i) the identification of an initial rate for a qualified individual based on:

1831 (A) standardized age bands submitted by participating insurers; and

1832 (B) wellness incentives for the individual as permitted by federal law; and

1833 (ii) the identification of a group risk factor to be applied to the initial age rate of a
1834 qualified individual based on the health conditions of all qualified individuals in the same
1835 employer group and, for small employers, in accordance with Sections 31A-30-105 and
1836 31A-30-106.1.

1837 (c) The plan adopted under Subsection (2)(a) shall outline how:

1838 (i) premium contributions for qualified individuals shall be submitted to the Health
1839 Insurance Exchange in the amount determined under Subsection (2)(b); and

1840 (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by
1841 qualified individuals within an employer group based on each individual's rating factor
1842 determined in accordance with the plan.

1843 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
1844 risk between insurers that:

1845 (i) identifies health care conditions subject to risk adjustment;

1846 (ii) establishes an adjustment amount for each identified health care condition;

1847 (iii) determines the extent to which an insurer has more or less individuals with an
1848 identified health condition than would be expected; and

1849 (iv) computes all risk adjustments.

1850 (e) The board may amend the plan if necessary to:

1851 [~~(i) incorporate large group defined contribution arrangement health benefit plans into~~
1852 ~~the defined contribution arrangement market risk adjuster mechanism created by this chapter;]~~

1853 [(~~ii~~) (i) maintain the proper functioning and solvency of the defined contribution
1854 arrangement market and the risk adjuster mechanism;

1855 ~~[(iii)]~~ (ii) mitigate significant issues of risk selection; or
1856 ~~[(iv)]~~ (iii) improve the administration of the risk adjuster mechanism [~~including~~
1857 opening enrollment periodically until January 1, 2011, for the purpose of testing the enrollment
1858 and risk adjusting process].

1859 (3) ~~[(a)]~~ The board shall establish a mechanism in which the participating carriers shall
1860 submit their plan base rates, rating factors, and premiums to [~~an independent actuary, appointed~~
1861 ~~by the board, for review prior to the publication of the premium rates on the Health Insurance~~
1862 ~~Exchange]~~ the commissioner for an actuarial review under the provisions of Section
1863 31A-30-115 prior to the publication of the premium rates on the Health Insurance Exchange.

1864 ~~[(b) The actuary appointed by the board shall:]~~

1865 ~~[(i) be compensated for the analysis under this section from fees established in~~
1866 ~~accordance with Section 63J-1-504:]~~

1867 ~~[(A) assessed by the board; and]~~

1868 ~~[(B) paid by all small employer carriers participating in the defined contribution~~
1869 ~~arrangement market and small employer carriers offering health benefit plans under Chapter~~
1870 ~~30, Part 1, Individual and Small Employer Group; and]~~

1871 ~~[(ii) review the information submitted:]~~

1872 ~~[(A) under Subsection (3)(a) for the purpose of verifying the validity of the rates, rating~~
1873 ~~factors, and premiums; and]~~

1874 ~~[(B) from carriers offering health benefit plans under Chapter 30, Part 1, Individual and~~
1875 ~~Small Employer Group:]~~

1876 ~~[(F) for the purpose of verifying underwriting and rating practices; and]~~

1877 ~~[(H) as the actuary determines is necessary.]~~

1878 ~~[(c) Fees collected under Subsection (3)(b) shall be used to pay the actuary for the~~
1879 ~~purpose of overseeing market conduct.]~~

1880 ~~[(d) The actuary shall:]~~

1881 ~~[(i) report aggregate data to the risk adjuster board;]~~

1882 ~~[(ii) contact carriers:]~~

1883 ~~[(A) to inform a carrier of the actuary's findings regarding the particular carrier; and]~~

1884 ~~[(B) to request a carrier to re-calculate or verify base rates, rating factors, and~~
1885 ~~premiums; and]~~

1886 ~~[(iii) share the actuary's analysis and data with the department for the purposes~~
1887 ~~described in Section 31A-30-106.1.]~~

1888 ~~[(e) A carrier shall re-submit premium rates if the department contacts the carrier under~~
1889 ~~Subsection (3).]~~

1890 Section 28. Section **63A-5-205** is amended to read:

1891 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**
1892 **coverage.**

1893 (1) As used in this section:

1894 (a) "Capital developments" has the same meaning as provided in Section 63A-5-104.

1895 (b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.

1896 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section
1897 34A-2-104 who:

1898 (i) works at least 30 hours per calendar week; and

1899 (ii) meets employer eligibility waiting requirements for health care insurance which
1900 may not exceed the first day of the calendar month following 90 days from the date of hire.

1901 (d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

1902 (e) "Qualified health insurance coverage" ~~[means at the time the contract is entered into~~
1903 ~~or renewed:]~~ is as defined in Section 26-40-115.

1904 ~~[(i) a health benefit plan and employer contribution level with a combined actuarial~~
1905 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
1906 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
1907 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
1908 ~~employee who reside or work in the state, in which:]~~

1909 ~~[(A) the employer pays at least 50% of the premium for the employee and the~~
1910 ~~dependents of the employee who reside or work in the state; and]~~

1911 ~~[(B) for purposes of calculating actuarial equivalency under this Subsection (1)(e)(i):]~~

1912 ~~[(F) rather than the benchmark plan's deductible, and the benchmark plan's~~
1913 ~~out-of-pocket maximum based on income levels:]~~

1914 ~~[(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

1915 ~~[(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]~~

1916 ~~[(H) dental coverage is not required; and]~~

1917 ~~[(H) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
1918 ~~not apply; or]~~

1919 ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
1920 ~~deductible that is either:]~~

1921 ~~[(F) the lowest deductible permitted for a federally qualified high deductible health~~
1922 ~~plan; or]~~

1923 ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~
1924 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
1925 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
1926 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
1927 ~~employer offered federally qualified high deductible plan;]~~

1928 ~~[(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
1929 ~~annual deductible; and]~~

1930 ~~[(C) under which the employer pays 75% of the premium for the employee and the~~
1931 ~~dependents of the employee who work or reside in the state.]~~

1932 (f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

1933 (2) In accordance with Title 63G, Chapter 6, Utah Procurement Code, the director may:

1934 (a) subject to Subsection (3), enter into contracts for any work or professional services
1935 which the division or the State Building Board may do or have done; and

1936 (b) as a condition of any contract for architectural or engineering services, prohibit the
1937 architect or engineer from retaining a sales or agent engineer for the necessary design work.

1938 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design
1939 or construction contracts entered into by the division or the State Building Board on or after
1940 July 1, 2009, and:

1941 (i) applies to a prime contractor if the prime contract is in the amount of \$1,500,000 or
1942 greater; and

1943 (ii) applies to a subcontractor if the subcontract is in the amount of \$750,000 or greater.

1944 (b) This Subsection (3) does not apply:

1945 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

1946 (ii) if the contract is a sole source contract;

1947 (iii) if the contract is an emergency procurement; or

1948 (iv) to a change order as defined in Section [~~63G-6-102~~] 63G-6-103, or a modification
1949 to a contract, when the contract does not meet the threshold required by Subsection (3)(a).

1950 (c) A person who intentionally uses change orders or contract modifications to
1951 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

1952 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that
1953 the contractor has and will maintain an offer of qualified health insurance coverage for the
1954 contractor's employees and the employees' dependents.

1955 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor
1956 shall demonstrate to the director that the subcontractor has and will maintain an offer of
1957 qualified health insurance coverage for the subcontractor's employees and the employees'
1958 dependents.

1959 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)
1960 during the duration of the contract is subject to penalties in accordance with administrative
1961 rules adopted by the division under Subsection (3)(f).

1962 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1963 requirements of Subsection (3)(d)(ii).

1964 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)
1965 during the duration of the contract is subject to penalties in accordance with administrative
1966 rules adopted by the division under Subsection (3)(f).

1967 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1968 requirements of Subsection (3)(d)(i).

1969 (f) The division shall adopt administrative rules:

1970 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1971 (ii) in coordination with:

1972 (A) the Department of Environmental Quality in accordance with Section 19-1-206;

1973 (B) the Department of Natural Resources in accordance with Section 79-2-404;

1974 (C) a public transit district in accordance with Section 17B-2a-818.5;

1975 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

1976 (E) the Department of Transportation in accordance with Section 72-6-107.5; and

1977 (F) the Legislature's Administrative Rules Review Committee; and

1978 (iii) which establish:

1979 (A) the requirements and procedures a contractor must follow to demonstrate to the
1980 director compliance with this Subsection (3) which shall include:

1981 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)
1982 or (ii) more than twice in any 12-month period; and

1983 (II) that the actuarially equivalent determination required for the qualified health
1984 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
1985 department or division with a written statement of actuarial equivalency from either:

1986 (Aa) the Utah Insurance Department;

1987 (Bb) an actuary selected by the contractor or the contractor's insurer; or

1988 (Cc) an underwriter who is responsible for developing the employer group's premium
1989 rates;

1990 (B) the penalties that may be imposed if a contractor or subcontractor intentionally
1991 violates the provisions of this Subsection (3), which may include:

1992 (I) a three-month suspension of the contractor or subcontractor from entering into
1993 future contracts with the state upon the first violation;

1994 (II) a six-month suspension of the contractor or subcontractor from entering into future
1995 contracts with the state upon the second violation;

1996 (III) an action for debarment of the contractor or subcontractor in accordance with
1997 Section 63G-6-804 upon the third or subsequent violation; and

1998 (IV) monetary penalties which may not exceed 50% of the amount necessary to
1999 purchase qualified health insurance coverage for an employee and the dependents of an
2000 employee of the contractor or subcontractor who was not offered qualified health insurance
2001 coverage during the duration of the contract; and

2002 (C) a website on which the department shall post the benchmark for the qualified
2003 health insurance coverage identified in Subsection (1)(e)[(†)].

2004 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or
2005 subcontractor who intentionally violates the provisions of this section shall be liable to the
2006 employee for health care costs that would have been covered by qualified health insurance
2007 coverage.

2008 (ii) An employer has an affirmative defense to a cause of action under Subsection
2009 (3)(g)(i) if:

2010 (A) the employer relied in good faith on a written statement of actuarial equivalency
2011 provided by:

2012 (I) an actuary; or

2013 (II) an underwriter who is responsible for developing the employer group's premium
2014 rates; or

2015 (B) the department determines that compliance with this section is not required under
2016 the provisions of Subsection (3)(b).

2017 (iii) An employee has a private right of action only against the employee's employer to
2018 enforce the provisions of this Subsection (3)(g).

2019 (h) Any penalties imposed and collected under this section shall be deposited into the
2020 Medicaid Restricted Account created by Section 26-18-402.

2021 (i) The failure of a contractor or subcontractor to provide qualified health insurance
2022 coverage as required by this section:

2023 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,
2024 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2025 Legal and Contractual Remedies; and

2026 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or
2027 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2028 or construction.

2029 (4) The judgment of the director as to the responsibility and qualifications of a bidder
2030 is conclusive, except in case of fraud or bad faith.

2031 (5) The division shall make all payments to the contractor for completed work in
2032 accordance with the contract and pay the interest specified in the contract on any payments that
2033 are late.

2034 (6) If any payment on a contract with a private contractor to do work for the division or
2035 the State Building Board is retained or withheld, it shall be retained or withheld and released as
2036 provided in Section 13-8-5.

2037 Section 29. Section **63C-9-403** is amended to read:

2038 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

2039 (1) For purposes of this section:

2040 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section

2041 34A-2-104 who:

2042 (i) works at least 30 hours per calendar week; and

2043 (ii) meets employer eligibility waiting requirements for health care insurance which
2044 may not exceed the first of the calendar month following 90 days from the date of hire.

2045 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2046 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
2047 ~~or renewed:~~] is as defined in Section 26-40-115.

2048 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
2049 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
2050 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
2051 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
2052 ~~employee who reside or work in the state, in which:]~~

2053 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
2054 ~~dependents of the employee who reside or work in the state; and]~~

2055 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]~~

2056 [~~(f) rather than the benchmark plan's deductible, and the benchmark plan's~~
2057 ~~out-of-pocket maximum based on income levels:]~~

2058 [~~(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

2059 [~~(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]~~

2060 [~~(H) dental coverage is not required; and]~~

2061 [~~(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
2062 ~~not apply; or]~~

2063 [(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a
2064 deductible that is either:]

2065 [(f) the lowest deductible permitted for a federally qualified high deductible health
2066 plan; or]

2067 [(H) a deductible that is higher than the lowest deductible permitted for a federally
2068 qualified high deductible health plan, but includes an employer contribution to a health savings
2069 account in a dollar amount at least equal to the dollar amount difference between the lowest
2070 deductible permitted for a federally qualified high deductible plan and the deductible for the
2071 employer offered federally qualified high deductible plan;]

2072 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
2073 ~~annual deductible; and]~~

2074 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
2075 ~~dependents of the employee who work or reside in the state.]~~

2076 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2077 (2) (a) Except as provided in Subsection (3), this section applies to a design or
2078 construction contract entered into by the board or on behalf of the board on or after July 1,
2079 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).

2080 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2081 amount of \$1,500,000 or greater.

2082 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2083 \$750,000 or greater.

2084 (3) This section does not apply if:

2085 (a) the application of this section jeopardizes the receipt of federal funds;

2086 (b) the contract is a sole source contract; or

2087 (c) the contract is an emergency procurement.

2088 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~]
2089 63G-6-103, or a modification to a contract, when the contract does not meet the initial
2090 threshold required by Subsection (2).

2091 (b) A person who intentionally uses change orders or contract modifications to
2092 circumvent the requirements of Subsection (2) is guilty of an infraction.

2093 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
2094 director that the contractor has and will maintain an offer of qualified health insurance
2095 coverage for the contractor's employees and the employees' dependents during the duration of
2096 the contract.

2097 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
2098 shall demonstrate to the executive director that the subcontractor has and will maintain an offer
2099 of qualified health insurance coverage for the subcontractor's employees and the employees'
2100 dependents during the duration of the contract.

2101 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2102 the duration of the contract is subject to penalties in accordance with administrative rules

2103 adopted by the division under Subsection (6).

2104 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2105 requirements of Subsection (5)(b).

2106 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2107 the duration of the contract is subject to penalties in accordance with administrative rules
2108 adopted by the department under Subsection (6).

2109 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2110 requirements of Subsection (5)(a).

2111 (6) The department shall adopt administrative rules:

2112 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2113 (b) in coordination with:

2114 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2115 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

2116 (iii) the State Building Board in accordance with Section 63A-5-205;

2117 (iv) a public transit district in accordance with Section 17B-2a-818.5;

2118 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

2119 (vi) the Legislature's Administrative Rules Review Committee; and

2120 (c) which establish:

2121 (i) the requirements and procedures a contractor must follow to demonstrate to the
2122 executive director compliance with this section which shall include:

2123 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2124 (b) more than twice in any 12-month period; and

2125 (B) that the actuarially equivalent determination required for the qualified health
2126 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
2127 department or division with a written statement of actuarial equivalency from either:

2128 (I) the Utah Insurance Department;

2129 (II) an actuary selected by the contractor or the contractor's insurer; or

2130 (III) an underwriter who is responsible for developing the employer group's premium
2131 rates;

2132 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2133 violates the provisions of this section, which may include:

2134 (A) a three-month suspension of the contractor or subcontractor from entering into
2135 future contracts with the state upon the first violation;

2136 (B) a six-month suspension of the contractor or subcontractor from entering into future
2137 contracts with the state upon the second violation;

2138 (C) an action for debarment of the contractor or subcontractor in accordance with
2139 Section 63G-6-804 upon the third or subsequent violation; and

2140 (D) monetary penalties which may not exceed 50% of the amount necessary to
2141 purchase qualified health insurance coverage for employees and dependents of employees of
2142 the contractor or subcontractor who were not offered qualified health insurance coverage
2143 during the duration of the contract; and

2144 (iii) a website on which the department shall post the benchmark for the qualified
2145 health insurance coverage identified in Subsection (1)(c)[(†)].

2146 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
2147 subcontractor who intentionally violates the provisions of this section shall be liable to the
2148 employee for health care costs that would have been covered by qualified health insurance
2149 coverage.

2150 (ii) An employer has an affirmative defense to a cause of action under Subsection
2151 (7)(a)(i) if:

2152 (A) the employer relied in good faith on a written statement of actuarial equivalency
2153 provided by:

2154 (I) an actuary; or

2155 (II) an underwriter who is responsible for developing the employer group's premium
2156 rates; or

2157 (B) the department determines that compliance with this section is not required under
2158 the provisions of Subsection (3) or (4).

2159 (b) An employee has a private right of action only against the employee's employer to
2160 enforce the provisions of this Subsection (7).

2161 (8) Any penalties imposed and collected under this section shall be deposited into the
2162 Medicaid Restricted Account created in Section 26-18-402.

2163 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2164 coverage as required by this section:

2165 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2166 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2167 Legal and Contractual Remedies; and

2168 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2169 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2170 or construction.

2171 Section 30. Section **63I-1-231** is amended to read:

2172 **63I-1-231. Repeal dates, Title 31A.**

2173 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.

2174 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.

2175 (3) Section 31A-22-625, Catastrophic coverage of mental health conditions, is repealed
2176 July 1, 2011.

2177 [~~4~~] Chapter 42a, Utah Statewide Risk Adjuster Act, is repealed July 1, 2016.]

2178 Section 31. Section **63J-1-602.2** is amended to read:

2179 **63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.**

2180 (1) Appropriations from the Technology Development Restricted Account created in
2181 Section 31A-3-104.

2182 (2) Appropriations from the Criminal Background Check Restricted Account created in
2183 Section 31A-3-105.

2184 (3) Appropriations from the Captive Insurance Restricted Account created in Section
2185 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that
2186 section free revenue.

2187 (4) Appropriations from the Title Licensee Enforcement Restricted Account created in
2188 Section 31A-23a-415.

2189 (5) The fund for operating the state's Federal Health Care Tax Credit Program, as
2190 provided in Section 31A-38-104.

2191 (6) Appropriations from the Health Insurance Actuarial Review Restricted Account
2192 created in Section 31A-30-115.

2193 [~~6~~] (7) The Special Administrative Expense Account created in Section 35A-4-506.

2194 [~~7~~] (8) Funding for a new program or agency that is designated as nonlapsing under
2195 Section 36-24-101.

2196 ~~[(8)]~~ (9) The Oil and Gas Conservation Account created in Section 40-6-14.5.
2197 ~~[(9)]~~ (10) The Off-Highway Access and Education Restricted Account created in
2198 Section 41-22-19.5.
2199 Section 32. Section **63M-1-2504** is amended to read:
2200 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
2201 (1) There is created within the Governor's Office of Economic Development the Office
2202 of Consumer Health Services.
2203 (2) The office shall:
2204 (a) in cooperation with the Insurance Department, the Department of Health, and the
2205 Department of Workforce Services, and in accordance with the electronic standards developed
2206 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:
2207 ~~[(i) is capable of providing access to private and government health insurance websites~~
2208 ~~and their electronic application forms and submission procedures;]~~
2209 (i) provides information to consumers about private and public health programs for
2210 which the consumer may qualify;
2211 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
2212 on the Health Insurance Exchange ~~[by an insurer for the:]; and~~
2213 ~~[(A) small employer group market;]~~
2214 ~~[(B) the individual market; and]~~
2215 ~~[(C) the defined contribution arrangement market; and]~~
2216 (iii) includes information and a link to enrollment in premium assistance programs and
2217 other government assistance programs;
2218 (b) ~~[facilitate a private sector method]~~ contract with one or more private vendors for:
2219 (i) administration of the enrollment process on the Health Insurance Exchange,
2220 including establishing a mechanism for consumers to compare health benefit plan features on
2221 the exchange and filter the plans based on consumer preferences;
2222 (ii) the collection of health insurance premium payments made for a single policy by
2223 multiple payers, including the policyholder, one or more employers of one or more individuals
2224 covered by the policy, government programs, and others ~~[by educating employers and insurers~~
2225 ~~about collection services available through private vendors, including financial institutions];~~
2226 and

- 2227 (iii) establishing a call center in accordance with Subsection (3);
- 2228 (c) assist employers with a free or low cost method for establishing mechanisms for the
- 2229 purchase of health insurance by employees using pre-tax dollars;
- 2230 ~~[(d) periodically convene health care providers, payers, and consumers to monitor the~~
- 2231 ~~progress being made regarding demonstration projects for health care delivery and payment~~
- 2232 ~~reform;]~~
- 2233 ~~[(e)]~~ (d) establish a list on the Health Insurance Exchange of insurance producers who,
- 2234 in accordance with Section 31A-30-209, are appointed producers for the ~~[defined contribution~~
- 2235 ~~arrangement market on the]~~ Health Insurance Exchange; and
- 2236 ~~[(f)]~~ (e) report to the Business and Labor Interim Committee and the Health System
- 2237 Reform Task Force prior to November 1, ~~[2010]~~ 2011, and prior to the Legislative interim day
- 2238 in November of each year thereafter regarding~~[-(f)]~~ the operations of the Health Insurance
- 2239 Exchange required by this chapter~~[-and]~~.
- 2240 ~~[(ii) the progress of the demonstration projects for health care payment and delivery~~
- 2241 ~~reform.]~~
- 2242 (3) A call center established by the office:
- 2243 (a) shall provide unbiased answers to questions concerning exchange operations, and
- 2244 plan information, to the extent the plan information is posted on the exchange by the insurer;
- 2245 and
- 2246 (b) may not:
- 2247 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;
- 2248 (ii) beginning July 1, 2011, receive producer compensation through the Health
- 2249 Insurance Exchange; and
- 2250 (iii) beginning July 1, 2011, be designated as the default producer for an employer
- 2251 group that enters the Health Insurance Exchange without a producer.
- 2252 ~~[(3)]~~ (4) The office:
- 2253 (a) may not:
- 2254 (i) regulate health insurers, health insurance plans, ~~[or]~~ health insurance producers, or
- 2255 health insurance premiums charged in the exchange;
- 2256 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or
- 2257 (iii) act as an appeals entity for resolving disputes between a health insurer and an

2258 insured; ~~and]~~
 2259 (b) may establish and collect a fee in accordance with Section 63J-1-504 for;
 2260 (i) the transaction cost of:
 2261 ~~[(i)]~~ (A) processing an application for a health benefit plan [from the Internet portal to
 2262 ~~an insurer; and];~~
 2263 ~~[(ii)]~~ (B) accepting, processing, and submitting multiple premium payment sources[-];
 2264 ~~and~~
 2265 (C) providing a mechanism for consumers to filter and compare health benefit plans in
 2266 the exchange based on consumer preferences; and
 2267 (ii) funding the call center established in accordance with Subsection (3); and
 2268 (c) shall separately itemize any fees established under Subsection (4)(b) as part of the
 2269 cost displayed for the employer selecting coverage on the exchange.

2270 Section 33. Section **63M-1-2506** is amended to read:

2271 **63M-1-2506. Health benefit plan information on Health Insurance Exchange --**
 2272 **Insurer transparency.**

2273 (1) (a) The office shall adopt administrative rules in accordance with Title 63G,
 2274 Chapter 3, Utah Administrative Rulemaking Act, ~~[that:]~~ that establish uniform electronic
 2275 standards for insurers, employers, brokers, consumers, and vendors to use when transmitting or
 2276 receiving information, uniform applications, waivers of coverage, or payments to, or from, the
 2277 Health Insurance Exchange.

2278 ~~[(i) establish uniform electronic standards for:]~~

2279 ~~[(A) a health insurer to use when:]~~

2280 ~~[(i) transmitting information to:]~~

2281 ~~[(Aa) the Insurance Department under Subsection 31A-22-613.5(2)(a)(ii); and]~~

2282 ~~[(Bb) the Health Insurance Exchange as required by this section;]~~

2283 ~~[(H) receiving information from the Health Insurance Exchange;]~~

2284 ~~[(Hh) receiving or transmitting the universal health application to or from the Health~~
 2285 ~~Insurance Exchange;]~~

2286 ~~[(B) facilitating the transmission and receipt of premium payments from multiple~~
 2287 ~~sources in the defined contribution arrangement market; and]~~

2288 ~~[(C) the use of the uniform health insurance application required by Section~~

2289 ~~31A-22-635 on the Health Insurance Exchange;]~~

2290 ~~[(ii) designate the level of detail that would be helpful for a concise consumer~~
2291 ~~comparison of the items described in Subsections (4) and (5) on the Health Insurance~~
2292 ~~Exchange;]~~

2293 (b) The administrative rules adopted by the office shall:

2294 (i) promote an efficient and consumer friendly process for shopping for and enrolling
2295 in a health benefit plan offered on the Health Insurance Exchange; and

2296 (ii) if appropriate, as determined by the office, comply with standards adopted at the
2297 national level.

2298 ~~[(iii)]~~ (2) The office shall assist the risk adjuster board created under Title 31A,
2299 Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined
2300 contribution market on the Health Insurance Exchange with the determination of when an
2301 employer is eligible to participate in the Health Insurance Exchange under Title 31A, Chapter
2302 30, Part 2, Defined Contribution Arrangements~~[-and]~~.

2303 ~~[(iv)]~~ (3) (a) The office shall create an advisory board to advise the exchange
2304 concerning the operation of the exchange, the consumer experience on the exchange, and
2305 transparency issues ~~[with]~~.

2306 (b) The advisory board shall have the following members:

2307 ~~[(A)]~~ (i) two health producers who are [registered] appointed producers with the Health
2308 Insurance Exchange;

2309 ~~[(B) two consumers;]~~

2310 ~~[(C) one representative from a large insurer who participates on the exchange;]~~

2311 ~~[(D) one representative from a small insurer who participates on the exchange;]~~

2312 (ii) two representatives from community-based, non-profit organizations;

2313 (iii) one representative from an employer that participates in the defined contribution
2314 market on the Health Insurance Exchange;

2315 (iv) up to four representatives from insurers who participate in the defined contribution
2316 market of the Health Insurance Exchange;

2317 ~~[(E)]~~ (v) one representative from the Insurance Department; and

2318 ~~[(F)]~~ (vi) one representative from the Department of Health.

2319 (c) Members of the advisory board shall serve without compensation.

2320 ~~[(b)] (4) The office shall post or facilitate the posting, on the Health Insurance~~
2321 ~~Exchange, of[-:(i)] the information required by this section [on the Health Insurance Exchange~~
2322 ~~created by this part; and (ii)] and Section 31A-22-635 and~~ links to websites that provide cost
2323 and quality information from the Department of Health Data Committee or neutral entities with
2324 a broad base of support from the provider and payer communities.

2325 ~~[(2) A health insurer shall use the uniform electronic standards when transmitting~~
2326 ~~information to the Health Insurance Exchange or receiving information from the Health~~
2327 ~~Insurance Exchange.]~~

2328 ~~[(3) (a) (i) An insurer who participates in the defined contribution arrangement market~~
2329 ~~under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements, shall post all plans~~
2330 ~~offered in the defined contribution arrangement market on the Health Insurance Exchange and~~
2331 ~~shall comply with the provisions of this section.]~~

2332 ~~[(ii) Beginning January 1, 2013, an insurer who offers a health benefit plan to a small~~
2333 ~~employer group in the state shall:]~~

2334 ~~[(A) post the health benefit plans in which the insurer is enrolling new groups on the~~
2335 ~~Health Insurance Exchange; and]~~

2336 ~~[(B) comply with the provisions of this section.]~~

2337 ~~[(b) An insurer who offers individual health benefit plans under Title 31A, Chapter 30,~~
2338 ~~Part 1, Individual and Small Employer Group:]~~

2339 ~~[(i) shall post on the Health Insurance Exchange the basic benefit plan required by~~
2340 ~~Section 31A-22-613.5; and]~~

2341 ~~[(ii) may publish on the Health Insurance Exchange any other health benefit plans that~~
2342 ~~it offers in the individual market.]~~

2343 ~~[(c) An insurer who posts a health benefit plan on the Health Insurance Exchange:]~~

2344 ~~[(i) shall comply with the provisions of this section for every health benefit plan it~~
2345 ~~posts on the Health Insurance Exchange; and]~~

2346 ~~[(ii) may not offer products on the Health Insurance Exchange that are not health~~
2347 ~~benefit plans.]~~

2348 ~~[(4) A health insurer shall provide the Health Insurance Exchange with the following~~
2349 ~~information for each health benefit plan submitted to the Health Insurance Exchange:]~~

2350 ~~[(a) plan design, benefits, and options offered by the health benefit plan including state~~

2351 mandates the plan does not cover;]

2352 [~~(b) provider networks;~~]

2353 [~~(c) wellness programs and incentives; and~~]

2354 [~~(d) descriptions of prescription drug benefits, exclusions, or limitations.~~]

2355 [~~(5)(a) An insurer offering any health benefit plan in the state shall submit the~~
2356 information described in Subsection (5)(b) to the Insurance Department in the electronic format
2357 required by Subsection (1).]

2358 [~~(b) An insurer who offers a health benefit plan in the state shall submit to the Health~~
2359 Insurance Exchange the following operational measures:]

2360 [~~(i) the percentage of claims paid by the insurer within 30 days of the date a claim is~~
2361 submitted to the insurer for the prior year; and]

2362 [~~(ii) for all health benefit plans offered by the insurer in the state, the claims denial and~~
2363 insurer transparency information developed in accordance with Subsection 31A-22-613.5(5).]

2364 [~~(c) The Insurance Department shall forward to the Health Insurance Exchange the~~
2365 information submitted by an insurer in accordance with this section and Section
2366 31A-22-613.5.]

2367 [~~(6) The Insurance Department shall post on the Health Insurance Exchange the~~
2368 Insurance Department's solvency rating for each insurer who posts a health benefit plan on the
2369 Health Insurance Exchange. The solvency rating for each carrier shall be based on
2370 methodology established by the Insurance Department by administrative rule and shall be
2371 updated each calendar year.]

2372 [~~(7) The commissioner may request information from an insurer under Section~~
2373 31A-22-613.5 to verify the data submitted to the Insurance Department and to the Health
2374 Insurance Exchange under this section.]

2375 [~~(8) A health insurer shall accept and process an application for a health benefit plan~~
2376 from the Health Insurance Exchange in accordance with this section and Section 31A-22-635.]

2377 Section 34. Section **72-6-107.5** is amended to read:

2378 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**
2379 **insurance coverage.**

2380 (1) For purposes of this section:

2381 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section

2382 34A-2-104 who:

2383 (i) works at least 30 hours per calendar week; and

2384 (ii) meets employer eligibility waiting requirements for health care insurance which
2385 may not exceed the first day of the calendar month following 90 days from the date of hire.

2386 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2387 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
2388 ~~or renewed:~~] is as defined in Section 26-40-115.

2389 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
2390 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
2391 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
2392 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
2393 ~~employee who reside or work in the state, in which:]~~

2394 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
2395 ~~dependents of the employee who reside or work in the state; and]~~

2396 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]~~

2397 [~~(f) rather than the benchmark plan's deductible, and the benchmark plan's~~
2398 ~~out-of-pocket maximum based on income levels:]~~

2399 [~~(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

2400 [~~(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;]~~

2401 [~~(H) dental coverage is not required; and]~~

2402 [~~(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
2403 ~~not apply; or]~~

2404 [(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a
2405 deductible that is either:]

2406 [~~(f) the lowest deductible permitted for a federally qualified high deductible health~~
2407 ~~plan; or]~~

2408 [~~(H) a deductible that is higher than the lowest deductible permitted for a federally~~
2409 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
2410 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
2411 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
2412 ~~employer offered federally qualified high deductible plan;]~~

2413 [~~(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
2414 ~~annual deductible; and]~~

2415 [~~(C) under which the employer pays 75% of the premium for the employee and the~~
2416 ~~dependents of the employee who work or reside in the state.]~~

2417 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2418 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered
2419 into by the department on or after July 1, 2009, for construction or design of highways and to a
2420 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

2421 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2422 amount of \$1,500,000 or greater.

2423 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2424 \$750,000 or greater.

2425 (3) This section does not apply if:

2426 (a) the application of this section jeopardizes the receipt of federal funds;

2427 (b) the contract is a sole source contract; or

2428 (c) the contract is an emergency procurement.

2429 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~
2430 63G-6-103], or a modification to a contract, when the contract does not meet the initial
2431 threshold required by Subsection (2).

2432 (b) A person who intentionally uses change orders or contract modifications to
2433 circumvent the requirements of Subsection (2) is guilty of an infraction.

2434 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
2435 the contractor has and will maintain an offer of qualified health insurance coverage for the
2436 contractor's employees and the employees' dependents during the duration of the contract.

2437 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
2438 demonstrate to the department that the subcontractor has and will maintain an offer of qualified
2439 health insurance coverage for the subcontractor's employees and the employees' dependents
2440 during the duration of the contract.

2441 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2442 the duration of the contract is subject to penalties in accordance with administrative rules
2443 adopted by the department under Subsection (6).

2444 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2445 requirements of Subsection (5)(b).

2446 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2447 the duration of the contract is subject to penalties in accordance with administrative rules
2448 adopted by the department under Subsection (6).

2449 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2450 requirements of Subsection (5)(a).

2451 (6) The department shall adopt administrative rules:

2452 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2453 (b) in coordination with:

2454 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2455 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

2456 (iii) the State Building Board in accordance with Section 63A-5-205;

2457 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

2458 (v) a public transit district in accordance with Section 17B-2a-818.5; and

2459 (vi) the Legislature's Administrative Rules Review Committee; and

2460 (c) which establish:

2461 (i) the requirements and procedures a contractor must follow to demonstrate to the
2462 department compliance with this section which shall include:

2463 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

2464 (b) more than twice in any 12-month period; and

2465 (B) that the actuarially equivalent determination required for qualified health insurance
2466 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2467 division with a written statement of actuarial equivalency from either:

2468 (I) the Utah Insurance Department;

2469 (II) an actuary selected by the contractor or the contractor's insurer; or

2470 (III) an underwriter who is responsible for developing the employer group's premium
2471 rates;

2472 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2473 violates the provisions of this section, which may include:

2474 (A) a three-month suspension of the contractor or subcontractor from entering into

2475 future contracts with the state upon the first violation;

2476 (B) a six-month suspension of the contractor or subcontractor from entering into future
2477 contracts with the state upon the second violation;

2478 (C) an action for debarment of the contractor or subcontractor in accordance with
2479 Section 63G-6-804 upon the third or subsequent violation; and

2480 (D) monetary penalties which may not exceed 50% of the amount necessary to
2481 purchase qualified health insurance coverage for an employee and a dependent of the employee
2482 of the contractor or subcontractor who was not offered qualified health insurance coverage
2483 during the duration of the contract; and

2484 (iii) a website on which the department shall post the benchmark for the qualified
2485 health insurance coverage identified in Subsection (1)(c)[(†)].

2486 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2487 subcontractor who intentionally violates the provisions of this section shall be liable to the
2488 employee for health care costs that would have been covered by qualified health insurance
2489 coverage.

2490 (ii) An employer has an affirmative defense to a cause of action under Subsection
2491 (7)(a)(i) if:

2492 (A) the employer relied in good faith on a written statement of actuarial equivalency
2493 provided by:

2494 (I) an actuary; or

2495 (II) an underwriter who is responsible for developing the employer group's premium
2496 rates; or

2497 (B) the department determines that compliance with this section is not required under
2498 the provisions of Subsection (3) or (4).

2499 (b) An employee has a private right of action only against the employee's employer to
2500 enforce the provisions of this Subsection (7).

2501 (8) Any penalties imposed and collected under this section shall be deposited into the
2502 Medicaid Restricted Account created in Section 26-18-402.

2503 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2504 coverage as required by this section:

2505 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,

2506 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2507 Legal and Contractual Remedies; and

2508 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2509 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2510 or construction.

2511 Section 35. Section **79-2-404** is amended to read:

2512 **79-2-404. Contracting powers of department -- Health insurance coverage.**

2513 (1) For purposes of this section:

2514 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2515 34A-2-104 who:

2516 (i) works at least 30 hours per calendar week; and

2517 (ii) meets employer eligibility waiting requirements for health care insurance which
2518 may not exceed the first day of the calendar month following 90 days from the date of hire.

2519 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2520 (c) "Qualified health insurance coverage" [~~means at the time the contract is entered into~~
2521 ~~or renewed;~~] is as defined in Section 26-40-115.

2522 [~~(i) a health benefit plan and employer contribution level with a combined actuarial~~
2523 ~~value at least actuarially equivalent to the combined actuarial value of the benchmark plan~~
2524 ~~determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and~~
2525 ~~a contribution level of 50% of the premium for the employee and the dependents of the~~
2526 ~~employee who reside or work in the state, in which;~~]

2527 [~~(A) the employer pays at least 50% of the premium for the employee and the~~
2528 ~~dependents of the employee who reside or work in the state; and]~~

2529 [~~(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):]~~

2530 [~~(F) rather than the benchmark plan's deductible, and the benchmark plan's~~
2531 ~~out-of-pocket maximum based on income levels;~~]

2532 [~~(Aa) the deductible is \$750 per individual and \$2,250 per family; and]~~

2533 [~~(Bb) the out-of-pocket maximum is \$3,000 per individual and \$9,000 per family;~~]

2534 [~~(H) dental coverage is not required; and]~~

2535 [~~(Hh) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do~~
2536 ~~not apply; or]~~

2537 ~~[(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has a~~
2538 ~~deductible that is either:]~~

2539 ~~[(f) the lowest deductible permitted for a federally qualified high deductible health~~
2540 ~~plan; or]~~

2541 ~~[(H) a deductible that is higher than the lowest deductible permitted for a federally~~
2542 ~~qualified high deductible health plan, but includes an employer contribution to a health savings~~
2543 ~~account in a dollar amount at least equal to the dollar amount difference between the lowest~~
2544 ~~deductible permitted for a federally qualified high deductible plan and the deductible for the~~
2545 ~~employer offered federally qualified high deductible plan;]~~

2546 ~~[(B) an out-of-pocket maximum that does not exceed three times the amount of the~~
2547 ~~annual deductible; and]~~

2548 ~~[(C) under which the employer pays 75% of the premium for the employee and the~~
2549 ~~dependents of the employee who work or reside in the state.]~~

2550 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2551 (2) (a) Except as provided in Subsection (3), this section applies a design or
2552 construction contract entered into by, or delegated to, the department or a division, board, or
2553 council of the department on or after July 1, 2009, and to a prime contractor or to a
2554 subcontractor in accordance with Subsection (2)(b).

2555 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2556 amount of \$1,500,000 or greater.

2557 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2558 \$750,000 or greater.

2559 (3) This section does not apply to contracts entered into by the department or a
2560 division, board, or council of the department if:

2561 (a) the application of this section jeopardizes the receipt of federal funds;

2562 (b) the contract or agreement is between:

2563 (i) the department or a division, board, or council of the department; and

2564 (ii) (A) another agency of the state;

2565 (B) the federal government;

2566 (C) another state;

2567 (D) an interstate agency;

- 2568 (E) a political subdivision of this state; or
- 2569 (F) a political subdivision of another state; or
- 2570 (c) the contract or agreement is:
 - 2571 (i) for the purpose of disbursing grants or loans authorized by statute;
 - 2572 (ii) a sole source contract; or
 - 2573 (iii) an emergency procurement.
- 2574 (4) (a) This section does not apply to a change order as defined in Section [~~63G-6-102~~
- 2575 63G-6-103, or a modification to a contract, when the contract does not meet the initial
- 2576 threshold required by Subsection (2).
 - 2577 (b) A person who intentionally uses change orders or contract modifications to
 - 2578 circumvent the requirements of Subsection (2) is guilty of an infraction.
 - 2579 (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department
 - 2580 that the contractor has and will maintain an offer of qualified health insurance coverage for the
 - 2581 contractor's employees and the employees' dependents during the duration of the contract.
 - 2582 (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor
 - 2583 shall demonstrate to the department that the subcontractor has and will maintain an offer of
 - 2584 qualified health insurance coverage for the subcontractor's employees and the employees'
 - 2585 dependents during the duration of the contract.
 - 2586 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
 - 2587 the duration of the contract is subject to penalties in accordance with administrative rules
 - 2588 adopted by the department under Subsection (6).
 - 2589 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
 - 2590 requirements of Subsection (5)(b).
 - 2591 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
 - 2592 the duration of the contract is subject to penalties in accordance with administrative rules
 - 2593 adopted by the department under Subsection (6).
 - 2594 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
 - 2595 requirements of Subsection (5)(a).
 - 2596 (6) The department shall adopt administrative rules:
 - 2597 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
 - 2598 (b) in coordination with:

- 2599 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
- 2600 (ii) a public transit district in accordance with Section 17B-2a-818.5;
- 2601 (iii) the State Building Board in accordance with Section 63A-5-205;
- 2602 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
- 2603 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
- 2604 (vi) the Legislature's Administrative Rules Review Committee; and
- 2605 (c) which establish:
 - 2606 (i) the requirements and procedures a contractor must follow to demonstrate
 - 2607 compliance with this section to the department which shall include:
 - 2608 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
 - 2609 (b) more than twice in any 12-month period; and
 - 2610 (B) that the actuarially equivalent determination required for qualified health insurance
 - 2611 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
 - 2612 division with a written statement of actuarial equivalency from either:
 - 2613 (I) the Utah Insurance Department;
 - 2614 (II) an actuary selected by the contractor or the contractor's insurer; or
 - 2615 (III) an underwriter who is responsible for developing the employer group's premium
 - 2616 rates;
 - 2617 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
 - 2618 violates the provisions of this section, which may include:
 - 2619 (A) a three-month suspension of the contractor or subcontractor from entering into
 - 2620 future contracts with the state upon the first violation;
 - 2621 (B) a six-month suspension of the contractor or subcontractor from entering into future
 - 2622 contracts with the state upon the second violation;
 - 2623 (C) an action for debarment of the contractor or subcontractor in accordance with
 - 2624 Section 63G-6-804 upon the third or subsequent violation; and
 - 2625 (D) monetary penalties which may not exceed 50% of the amount necessary to
 - 2626 purchase qualified health insurance coverage for an employee and a dependent of an employee
 - 2627 of the contractor or subcontractor who was not offered qualified health insurance coverage
 - 2628 during the duration of the contract; and
 - 2629 (iii) a website on which the department shall post the benchmark for the qualified

2630 health insurance coverage identified in Subsection (1)(c)[(†)].

2631 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2632 subcontractor who intentionally violates the provisions of this section shall be liable to the
2633 employee for health care costs that would have been covered by qualified health insurance
2634 coverage.

2635 (ii) An employer has an affirmative defense to a cause of action under Subsection
2636 (7)(a)(i) if:

2637 (A) the employer relied in good faith on a written statement of actuarial equivalency
2638 provided by:

2639 (I) an actuary; or

2640 (II) an underwriter who is responsible for developing the employer group's premium
2641 rates; or

2642 (B) the department determines that compliance with this section is not required under
2643 the provisions of Subsection (3) or (4).

2644 (b) An employee has a private right of action only against the employee's employer to
2645 enforce the provisions of this Subsection (7).

2646 (8) Any penalties imposed and collected under this section shall be deposited into the
2647 Medicaid Restricted Account created in Section 26-18-402.

2648 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2649 coverage as required by this section:

2650 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2651 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
2652 Legal and Contractual Remedies; and

2653 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2654 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2655 or construction.

2656 **Section 36. Repealer.**

2657 This bill repeals:

2658 **Section 31A-42a-101 (Effective 01/01/13), Title.**

2659 **Section 31A-42a-102 (Effective 01/01/13), Definitions.**

2660 **Section 31A-42a-201 (Effective 01/01/13), Creation of defined contribution market**

2661 **risk adjuster mechanism -- Board of directors -- Appointment -- Terms -- Quorum -- Plan**
2662 **preparation.**

2663 Section 31A-42a-202 (Effective 01/01/13), Contents of plan.

2664 Section 31A-42a-203 (Effective 01/01/13), Powers and duties of board.

2665 Section 31A-42a-204 (Effective 01/01/13), Powers of commissioner.

2666 Section 37. **Health System Reform Task Force -- Creation -- Membership --**
2667 **Interim rules followed -- Compensation -- Staff.**

2668 (1) There is created the Health System Reform Task Force consisting of the following
2669 11 members:

2670 (a) four members of the Senate appointed by the president of the Senate, no more than
2671 three of whom may be from the same political party; and

2672 (b) seven members of the House of Representatives appointed by the speaker of the
2673 House of Representatives, no more than five of whom may be from the same political party.

2674 (2) (a) The president of the Senate shall designate a member of the Senate appointed
2675 under Subsection (1)(a) as a cochair of the committee.

2676 (b) The speaker of the House of Representatives shall designate a member of the House
2677 of Representatives appointed under Subsection (1)(b) as a cochair of the committee.

2678 (3) In conducting its business, the committee shall comply with the rules of legislative
2679 interim committees.

2680 (4) Salaries and expenses of the members of the committee shall be paid in accordance
2681 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
2682 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
2683 Sessions.

2684 (5) The Office of Legislative Research and General Counsel shall provide staff support
2685 to the committee.

2686 Section 38. **Duties -- Interim report.**

2687 (1) The task force shall review and make recommendations on the following issues:

2688 (a) the state's response to federal health care reform, including whether the state should
2689 develop an American Health Benefit Exchange under the federal Affordable Care Act for
2690 individual health benefit plans, individual premium assistance, tax credits, and Medicaid
2691 eligibility determinations;

- 2692 (b) legislation necessary to implement:
- 2693 (i) the governance structure for the Health Insurance Exchange to:
- 2694 (A) preserve the market-based defined contribution model for employers in the Health
- 2695 Insurance Exchange;
- 2696 (B) provide better control of state expenditures on health care for state employees,
- 2697 retirees and their families;
- 2698 (C) incentives to improve health among state employees; and
- 2699 (D) position Utah to continue with a market based, consumer driven insurance
- 2700 exchange;
- 2701 (ii) an operational blue print for the Health Insurance Exchange to promote an
- 2702 appropriate balance between private sector solutions and efficiencies for the exchange and state
- 2703 regulatory functions related to insurance market conduct; and
- 2704 (iii) funding requirements associated with the governance structure and better use of
- 2705 the Public Employees' Benefit and Insurance Program assets and competencies;
- 2706 (c) which market regulatory functions should be given to the Health Insurance
- 2707 Exchange and which should remain with the Insurance Department, the Department of Health,
- 2708 or the Department of Workforce Services;
- 2709 (d) policy and guidance regarding the state's implementation of the small group defined
- 2710 contribution arrangement market on the Health Insurance Exchange, including the consumer
- 2711 experience and information on the exchange concerning cost, quality, and transparency;
- 2712 (e) whether the risk adjuster mechanism in the exchange should be modified;
- 2713 (f) health care cost containment issues, including:
- 2714 (i) progress on the demonstration projects and grants that involve health care providers
- 2715 and payers to provide systemwide aligned incentives for the appropriate delivery of, and
- 2716 payment for, health care; and
- 2717 (ii) effective tools for reducing the cost or perceived costs of medical malpractice
- 2718 liability in the health care system; and
- 2719 (g) the appropriate balance of cost and benefits provided by insurance plans available
- 2720 on the exchange, including possible consideration of spiritual care, vision care, and dental
- 2721 services.
- 2722 (2) The task force shall coordinate with the Legislative Retirement and Independent

2723 Entities Interim Committee when it studies and makes recommendations regarding operational
2724 functions of the Health Insurance Exchange as it relates to state expenditures for health
2725 insurance for public employees, retirees and their families.

2726 (3) A final report, including any proposed legislation shall be presented to the Health
2727 and Human Services Interim Committee before November 30, 2011.

2728 Section 39. **Intent language regarding lapsing of money.**

2729 It is the intent of the Legislature that money received by the Insurance Department
2730 during fiscal year 2010-11 under Section 31A-30-115 shall be considered dedicated credits and
2731 in closing out the fiscal year 2010-11 the unspent dedicated credits shall lapse to the Health
2732 Insurance Actuarial Review Restricted Account.

2733 Section 40. **Repeal date.**

2734 (1) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Sections 48 and 49,
2735 which enacted the 2010 Health System Reform Task Force.

2736 (2) This bill repeals Uncodified Laws of Utah 2010, Chapter 68, Section 50,
2737 Subsection (3), which provided a future effective date of January 1, 2013, for Title 31A,
2738 Chapter 42a, Utah Statewide Risk Adjuster Act.

2739 (3) The Health System Reform Task Force created in Sections 34 and 35 of this bill is
2740 repealed on December 30, 2011.