

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH REFORM AMENDMENTS

2014 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

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



26 incorporate the Access Utah program.

27 ▶ amends the Utah Health Data Authority Act to facilitate:

- 28 • the coordination of eligibility for health insurance benefits; and
- 29 • cost and quality reports for episodes of care;

30 ▶ amends the health insurance navigator license chapter of the Insurance Code to:

- 31 • create two types of navigator licenses;
- 32 • establish different training for the types of licenses; and
- 33 • add an exception to the license requirement for Indian health centers;

34 ▶ amends the state Comprehensive Health Insurance Pool to:

- 35 • close the pool to new enrollees;
- 36 • pay out claims incurred by enrollees; and
- 37 • close down the business of the pool;

37a **H→** ▶ **permits an enrollee to re-new an insurance plan as long as permitted by federal**
 37b **policy;** ←**H**

38 ▶ establishes the state option for calculating the cost to the state if the state mandates
 39 additional benefits to the PPACA essential health benefits;

40 ▶ creates the Individual and Small Employer Risk Adjustment Act, which:

- 41 • requires the insurance commissioner to work with stakeholders to develop a
 42 state based risk adjustment program for the individual and small group market;
- 43 • describes the risk adjustment models the commissioner may consider;
- 44 • requires the commissioner to report to the Legislature before implementing a

45 risk adjustment model;

- 46 • authorizes the commissioner to set fees for the operation of the risk adjustment
 47 program; and

- 48 • establishes an Individual and Small Employer Risk Adjustment Enterprise Fund
 49 for the operation of the program;

50 ▶ requires the Office of Consumer Health Services, which runs the small employer
 51 health insurance exchange, to provide the form required for the federal small
 52 employer premium tax credit to small employers who purchase qualified health
 53 plans; and

54 ▶ makes technical and conforming amendments.

55 **Money Appropriated in this Bill:**

56 None

57 **Other Special Clauses:**

58 This bill provides an effective date.

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

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

63 **Utah Code Sections Affected:**

64 AMENDS:

65 **17B-2a-818.5**, as last amended by Laws of Utah 2012, Chapter 347

66 **19-1-206**, as last amended by Laws of Utah 2012, Chapter 347

67 **26-18-18**, as enacted by Laws of Utah 2013, Chapter 477

68 **26-33a-106.1**, as last amended by Laws of Utah 2012, Chapter 279

69 **26-33a-106.5**, as last amended by Laws of Utah 2012, Chapter 279

70 **26-33a-109**, as last amended by Laws of Utah 2010, Chapter 68

71 **31A-4-115**, as last amended by Laws of Utah 2002, Chapter 308

72 **31A-8-402.3**, as last amended by Laws of Utah 2004, Chapter 329

73 **31A-22-721**, as last amended by Laws of Utah 2011, Chapter 284

74 **31A-23b-205**, as enacted by Laws of Utah 2013, Chapter 341

75 **31A-23b-206**, as enacted by Laws of Utah 2013, Chapter 341

76 **31A-23b-211**, as enacted by Laws of Utah 2013, Chapter 341

77 **31A-29-106**, as last amended by Laws of Utah 2013, Chapter 319

78 **31A-29-110**, as last amended by Laws of Utah 2012, Chapter 347

79 **31A-29-111**, as last amended by Laws of Utah 2012, Chapters 158 and 347

80 **31A-29-113**, as last amended by Laws of Utah 2013, Chapter 319

81 **31A-29-114**, as last amended by Laws of Utah 2006, Chapter 95

82 **31A-29-115**, as last amended by Laws of Utah 2004, Chapter 2

83 **31A-30-103**, as last amended by Laws of Utah 2013, Chapter 168

84 **31A-30-107**, as last amended by Laws of Utah 2009, Chapter 12

85 **31A-30-108**, as last amended by Laws of Utah 2011, Chapter 284

86 **31A-30-117**, as enacted by Laws of Utah 2013, Chapter 341

87 **63A-5-205**, as last amended by Laws of Utah 2012, Chapter 347

88 [63C-9-403](#), as last amended by Laws of Utah 2012, Chapter 347
 89 [63I-1-231 \(Effective 07/01/14\)](#), as last amended by Laws of Utah 2013, Chapters 261
 90 and 417
 91 [63M-1-2504](#), as last amended by Laws of Utah 2013, Chapter 255
 92 [72-6-107.5](#), as last amended by Laws of Utah 2012, Chapter 347
 93 [79-2-404](#), as last amended by Laws of Utah 2012, Chapter 347

94 ENACTS:

95 [26-18-20](#), Utah Code Annotated 1953
 96 [31A-23b-202.5](#), Utah Code Annotated 1953
 97 [31A-30-118](#), Utah Code Annotated 1953
 98 [31A-30-301](#), Utah Code Annotated 1953
 99 [31A-30-302](#), Utah Code Annotated 1953
 100 [31A-30-303](#), Utah Code Annotated 1953

101 **Utah Code Sections Affected by Coordination Clause:**

102 [26-33a-106.1](#), as last amended by Laws of Utah 2012, Chapter 279
 103 [31A-23b-205](#), as enacted by Laws of Utah 2013, Chapter 341
 104 [31A-23b-206](#), as enacted by Laws of Utah 2013, Chapter 341

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

107 Section 1. Section [17B-2a-818.5](#) is amended to read:

108 **[17B-2a-818.5](#). Contracting powers of public transit districts -- Health insurance**
 109 **coverage.**

110 (1) For purposes of this section:

111 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
 112 [34A-2-104](#) who:

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

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

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

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

119 (d) "Subcontractor" has the same meaning provided for in Section [63A-5-208](#).
120 (2) (a) Except as provided in Subsection (3), this section applies to a design or
121 construction contract entered into by the public transit district on or after July 1, 2009, and to a
122 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

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

125 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
126 \$750,000 or greater.

127 (3) This section does not apply if:

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

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

130 (c) the contract is an emergency procurement.

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

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

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

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

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

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

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

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

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

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

155 (a) in coordination with:

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

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

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

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

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

161 (b) which establish:

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

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

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

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

169 (I) the Utah Insurance Department;

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

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

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

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

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

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

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

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

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

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

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

195 (I) actuary; or

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

197 or

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

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

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

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

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

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

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

213 **19-1-206. Contracting powers of department -- Health insurance coverage.**

214 (1) For purposes of this section:

215 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
216 34A-2-104 who:

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

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

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

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

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

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

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

230 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
231 \$750,000 or greater.

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

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

235 (b) the contract or agreement is between:

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

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

238 (B) the federal government;

239 (C) another state;

240 (D) an interstate agency;

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

242 (F) a political subdivision of another state;

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

246 (d) the contract is:

247 (i) a sole source contract; or

248 (ii) an emergency procurement.

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

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

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

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

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

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

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

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

272 (6) The department shall adopt administrative rules:

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

274 (b) in coordination with:
275 (i) a public transit district in accordance with Section 17B-2a-818.5;
276 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
277 (iii) the State Building Board in accordance with Section 63A-5-205;
278 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
279 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
280 (vi) the Legislature's Administrative Rules Review Committee; and
281 (c) which establish:
282 (i) the requirements and procedures a contractor shall follow to demonstrate to the
283 public transit district compliance with this section that shall include:
284 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
285 (b) more than twice in any 12-month period; and
286 (B) that the actuarially equivalent determination required for the qualified health
287 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
288 department or division with a written statement of actuarial equivalency from either:
289 (I) the Utah Insurance Department;
290 (II) an actuary selected by the contractor or the contractor's insurer; or
291 (III) an underwriter who is responsible for developing the employer group's premium
292 rates;
293 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
294 violates the provisions of this section, which may include:
295 (A) a three-month suspension of the contractor or subcontractor from entering into
296 future contracts with the state upon the first violation;
297 (B) a six-month suspension of the contractor or subcontractor from entering into future
298 contracts with the state upon the second violation;
299 (C) an action for debarment of the contractor or subcontractor in accordance with
300 Section 63G-6a-904 upon the third or subsequent violation; and
301 (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%
302 of the amount necessary to purchase qualified health insurance coverage for an employee and
303 the dependents of an employee of the contractor or subcontractor who was not offered qualified
304 health insurance coverage during the duration of the contract; and

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

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

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

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

315 (I) an actuary; or

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

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

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

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

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

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

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

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

333 **26-18-18. Optional Medicaid expansion.**

334 (1) For purposes of this section:

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

336 (i) do not qualify for the state's Medicaid program; and
337 (ii) the Centers for Medicare and Medicaid Services within the United States
338 Department of Health and Human Services would otherwise determine are eligible for funding
339 at the enhanced federal medical assistance percentage available under PPACA beginning
340 January 1, 2014.

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

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

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

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

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

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

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

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

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

358 **26-18-20. Access Utah -- Eligibility -- Defined contribution.**

359 (1) For purposes of this section:

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

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

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

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

367 (i) begin on January 1, 2015, and end on January 1, 2017; and
368 (ii) provide a defined contribution to eligible individuals in accordance with this
369 section.

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

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

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

377 (ii) (A) is medically frail; or

378 (B) is an adult with a child; and

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

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

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

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

387 (i) a commercial health insurance policy; or

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

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

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

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

396 (ii) integrate physical health and behavioral health services.

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

398 Force on or before November 1, 2016, regarding:

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

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

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

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

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

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

413 (ii) the modification of benefits will:

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

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

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

419 **26-33a-106.1. Health care cost and reimbursement data.**

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

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

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

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

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

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

429 Association;]

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

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

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

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

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

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

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

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

441 [(i) (a) establish a plan for collecting data from data suppliers, as defined in Section
442 26-33a-102, to determine measurements of cost and reimbursements for risk-adjusted episodes
443 of health care;

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

449 (i) risk adjusting; and

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

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

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

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

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

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

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

460 States Bureau of Labor Statistics;

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

462 ~~[(H)]~~ (C) as demonstrated by data available to the committee~~[-];~~ and

463 ~~H~~→ ~~[(iii)]~~ (d) **provide on** ←~~H~~ at least a monthly basis, enrollment data collected by the

463a committee to a

464 not-for-profit, broad-based coalition of state health care insurers and health care providers that

465 are involved in the standardized electronic exchange of health data as described in Section

466 31A-22-614.5, to the extent necessary:

467 (A) for the department or the Medicaid Office of the Inspector General to determine

468 insurance enrollment of an individual for the purpose of determining Medicaid third part

469 liability;

470 (B) for an insurer that is a data supplier, to determine insurance enrollment of an

471 individual for the purpose of coordination of health care benefits; and

472 (C) for a health care provider, to determine insurance enrollment for a patient for the

473 purpose of claims submission by the health care provider.

474 (2) (a) The Medicaid Office of Inspector General shall annually report to the

475 Legislature's Health and Human Services Interim Committee regarding how the office used the

476 data obtained under Subsection (1)(c)(iii) and the results of obtaining the data.

477 (b) A data supplier shall not be liable for a breach of or unlawful disclosure of the data

478 obtained by an entity described in Subsection (1)(c)(iii).

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

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

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

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

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

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

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

486 **26-33a-106.5. Comparative analyses.**

487 (1) The committee may publish compilations or reports that compare and identify

488 health care providers or data suppliers from the data it collects under this chapter or from any

489 other source.

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

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

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

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

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

498 (i) be published at least annually; and

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

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

501 (B) charges; and

502 (C) nationally recognized patient safety standards.

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

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

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

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

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

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

519 (i) routine and preventive care; and

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

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

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

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

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

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

533 (c) The department:

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

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

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

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

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

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

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

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

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

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

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

562 **26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.**

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

564 (a) the individual has authorized the disclosure; or

565 (b) the disclosure complies with the provisions of:

566 (i) this section[-];

567 (ii) insurance enrollment and coordination of benefits under Subsection

568 26-33a-104(1)(b); or

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

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

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

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

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

577 (a) be for a specified period; or

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

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

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

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

- 586 (a) without prior approval of the department; and
- 587 (b) unless the identifiable health data is disclosed or identified by control number only.

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

589 **31A-4-115. Plan of orderly withdrawal.**

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

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

- 595 (i) Subsection 31A-30-107(3)(e); or
- 596 (ii) Subsection 31A-30-107.1(3)(e).

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

- 598 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and
- 599 (b) include provisions for:

- 600 (i) meeting the insurer's contractual obligations;
- 601 (ii) providing services to its Utah policyholders and claimants;
- 602 (iii) meeting any applicable statutory obligations; and
- 603 (iv) (A) the payment of a withdrawal fee of \$50,000 to the Utah Comprehensive Health

604 Insurance Pool if:

- 605 (I) the insurer is an accident and health insurer; and
- 606 (II) the insurer's line of business is not assumed or placed with another insurer
607 approved by the commissioner; or

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

- 609 (I) the insurer is not an accident and health insurer; and
- 610 (II) the insurer's line of business is not assumed or placed with another insurer
611 approved by the commissioner.

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

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

- 615 (b) meet the insurer's contractual obligations;
- 616 (c) provide service to the insurer's Utah policyholders and claimants; and
- 617 (d) meet any applicable statutory obligations.

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

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

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

625 (b) the insurer:

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

627 (ii) intends to:

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

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

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

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

632 (b) reduces its total annual premium volume by 75% or more in any year without

633 having submitted a plan or receiving the commissioner's approval.

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

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

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

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

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

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

642 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**

643 **plans.**

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

- 646 (a) with respect to all eligible employees and dependents; and
- 647 (b) at the option of the plan sponsor.
- 648 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed~~[(a)]~~
- 649 for a network plan, if:
 - 650 ~~[(i)]~~ (a) there is no longer any enrollee under the group health plan who lives, resides,
 - 651 or works in:
 - 652 ~~[(A)]~~ (i) the service area of the insurer; or
 - 653 ~~[(B)]~~ (ii) the area for which the insurer is authorized to do business; ~~[and] or~~
 - 654 ~~[(ii)]~~ in the case of the small employer market, the insurer applies the same criteria the
 - 655 insurer would apply in denying enrollment in the plan under Subsection ~~31A-30-108~~(7); or]
 - 656 (b) for coverage made available in the small or large employer market only through an
 - 657 association, if:
 - 658 (i) the employer's membership in the association ceases; and
 - 659 (ii) the coverage is terminated uniformly without regard to any health status-related
 - 660 factor relating to any covered individual.
 - 661 (3) A health benefit plan for a plan sponsor may be discontinued if:
 - 662 (a) a condition described in Subsection (2) exists;
 - 663 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
 - 664 terms of the contract;
 - 665 (c) the plan sponsor:
 - 666 (i) performs an act or practice that constitutes fraud; or
 - 667 (ii) makes an intentional misrepresentation of material fact under the terms of the
 - 668 coverage;
 - 669 (d) the insurer:
 - 670 (i) elects to discontinue offering a particular health benefit product delivered or issued
 - 671 for delivery in this state; and
 - 672 (ii) (A) provides notice of the discontinuation in writing:
 - 673 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
 - 674 (II) at least 90 days before the date the coverage will be discontinued;
 - 675 (B) provides notice of the discontinuation in writing:
 - 676 (I) to the commissioner; and

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

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

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

681 or

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

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

686 (I) the claims experience of a plan sponsor;

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

688 (III) any health status-related factor relating to any new participant or beneficiary who

689 may become eligible for the coverage; or

690 (e) the insurer:

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

692 (A) the small employer market;

693 (B) the large employer market; or

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

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

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

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

698 (B) provides notice of the discontinuation in writing:

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

700 to reside; and

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

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

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

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

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

- 708 (b) for noncompliance with the insurer's:
- 709 (i) minimum participation requirements; or
- 710 (ii) employer contribution requirements.
- 711 (5) A small employer health benefit plan may be discontinued or nonrenewed:
- 712 (a) if a condition described in Subsection (2) exists; or
- 713 (b) for noncompliance with the insurer's employer contribution requirements.
- 714 (6) A small employer health benefit plan may be nonrenewed:
- 715 (a) if a condition described in Subsection (2) exists; or
- 716 (b) for noncompliance with the insurer's minimum participation requirements.
- 717 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 718 discontinued if after issuance of coverage the eligible employee:
- 719 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
- 720 or
- 721 (ii) makes an intentional misrepresentation of material fact in connection with the
- 722 coverage.
- 723 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
- 724 (i) 12 months after the date of discontinuance; and
- 725 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
- 726 to reenroll.
- 727 (c) At the time the eligible employee's coverage is discontinued under Subsection
- 728 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
- 729 discontinued.
- 730 (d) An eligible employee may not be discontinued under this Subsection (7) because of
- 731 a fraud or misrepresentation that relates to health status.
- 732 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
- 733 the employer:
- 734 (a) with respect to coverage provided to an employer member of the association; and
- 735 (b) if the health benefit plan is made available by an insurer in the employer market
- 736 only through:
- 737 (i) an association;
- 738 (ii) a trust; or

739 (iii) a discretionary group.

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

741 (a) at the time of coverage renewal; and

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

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

744 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
745 **nonrenewal.**

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

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

749 (b) at the option of the plan sponsor.

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

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

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

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

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

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

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

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

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

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

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

767 (c) the plan sponsor:

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

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

770 coverage;

771 (d) the insurer:

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

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

775 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
776 (II) at least 90 days before the date the coverage will be discontinued;

777 (B) provides notice of the discontinuation in writing:

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

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

783 (I) by the insurer in the market; or
784 (II) in the case of a large employer, any other health benefit plan currently being
785 offered in that market; and

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

788 (I) the claims experience of a plan sponsor;
789 (II) any health status-related factor relating to any covered participant or beneficiary; or
790 (III) any health status-related factor relating to a new participant or beneficiary who
791 may become eligible for coverage; or

792 (e) the insurer:

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

794 (A) in the small employer market; or
795 (B) the large employer market; or
796 (C) both the small and large employer markets; and

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

798 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
799 (II) at least 180 days before the date the coverage will be discontinued;

800 (B) provides notice of the discontinuation in writing:

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

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

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

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

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

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

810 (b) for noncompliance with the insurer's:

811 (i) minimum participation requirements; or

812 (ii) employer contribution requirements.

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

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

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

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

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

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

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

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

822 or

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

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

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

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

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

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

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

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

- 840 (i) to promote competition; or
- 841 (ii) to resolve inequity in the marketplace.

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

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

- 845 (a) at the time of coverage renewal; and
- 846 (b) if the modification is effective uniformly among all plans with a particular product
847 or service.

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

- 850 (a) with respect to coverage provided to an employer member of the association; and
- 851 (b) if the health benefit plan is made available by an insurer in the employer market
852 only through:

- 853 (i) an association;
- 854 (ii) a trust; or
- 855 (iii) a discretionary group.

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

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

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

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

866 **31A-23b-202.5. License types.**

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

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

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

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

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

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

882 **31A-23b-205. Examination and training requirements.**

883 (1) The commissioner may require [~~applicants~~] an applicant for a license to pass an
884 examination and complete a training program as a requirement for a license.

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

886 (a) the duties and functions of a navigator;

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

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

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

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

- 894 (a) accident and health insurance plans;
895 (b) qualifications for and enrollment in public programs;
896 (c) qualifications for and enrollment in premium subsidies;
897 (d) cultural and linguistic competence;
898 (e) conflict of interest standards;
899 (f) exchange functions; and
900 (g) other requirements that may be adopted by the commissioner by administrative
901 rule.

902 (5) (a) For the navigator line of authority, the training required by Subsection (1) shall
903 consist of at least 21 credit hours of training before obtaining the license, which shall include at
904 least two hours of training on:

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

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

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

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

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

916 ~~[(5)]~~ (6) This section applies only to [applicants who are natural persons] an applicant
917 who is a natural person.

918 Section 13. Section **31A-23b-206** is amended to read:

919 **31A-23b-206. Continuing education requirements.**

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

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

924 (b) The commissioner may state a continuing education requirement in terms of hours

925 of instruction received in:

- 926 (i) accident and health insurance;
- 927 (ii) qualification for and enrollment in public programs;
- 928 (iii) qualification for and enrollment in premium subsidies;
- 929 (iv) cultural competency;
- 930 (v) conflict of interest standards; and
- 931 (vi) other exchange functions.

932 (3) (a) ~~[Continuing]~~ For a navigator line of authority, continuing education
 933 requirements shall require:

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

936 (ii) that ~~[3]~~ at least two of the ~~[24]~~ 12 credit hours described in Subsection (3)(a)(i) be
 937 ethics courses; ~~[and]~~

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

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

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

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

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

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

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

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

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

958 (i) classroom attendance;

959 (ii) home study;

960 (iii) watching a video recording; or

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

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

963 ~~[(e)]~~ (d) A licensee may obtain continuing education hours at any time during the

964 ~~[two-year]~~ one-year license period.

965 ~~[(d)]~~ (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
966 Act, the commissioner shall, by rule: ~~[(i) publish a list of insurance professional designations~~
967 ~~whose continuing education requirements can be used to meet the requirements for continuing~~
968 ~~education under Subsection (3)(b); and (ii)]~~, authorize one or more continuing education
969 providers, including a state or national professional producer or consultant associations, to:

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

971 ~~[(B)]~~ (ii) collect a reasonable fee for funding and administration of a continuing
972 education program, subject to the review and approval of the commissioner.

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

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

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

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

982 Section 14. Section **31A-23b-211** is amended to read:

983 **31A-23b-211. Exceptions to navigator licensing.**

984 (1) For purposes of this section:

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

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

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

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

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

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

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

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

999 (c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants,
1000 and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to
1001 sell, solicit, or negotiate accident and health insurance plans;

1002 (d) an officer, director, or employee of a navigator:

1003 (i) who does not receive compensation or commission from an insurer issuing an
1004 insurance contract, an agency administering a public program, an individual who enrolled in a
1005 public program or insurance product, or an exchange; and

1006 (ii) whose activities:

1007 (A) are executive, administrative, managerial, clerical, or a combination thereof;

1008 (B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the
1009 enrollment in a public program offered through the exchange;

1010 (C) are in the capacity of a special agent or agency supervisor assisting an insurance
1011 producer or navigator;

1012 (D) are limited to providing technical advice and assistance to a licensed insurance
1013 producer or navigator; or

1014 (E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment
1015 in a public program; [~~and~~]

1016 (e) a person who does not sell, solicit, or negotiate insurance and is not directly or
1017 indirectly compensated by an insurer issuing an insurance contract, an agency administering a

1018 public program, an individual who enrolled in a public program or insurance product, or an
1019 exchange, including:

1020 (i) an employer, association, officer, director, employee, or trustee of an employee trust
1021 plan who is engaged in the administration or operation of a program:

1022 (A) of employee benefits for the employer's or association's own employees or the
1023 employees of a subsidiary or affiliate of an employer or association; and

1024 (B) that involves the use of insurance issued by an insurer or enrollment in a public
1025 health plan on an exchange;

1026 (ii) an employee of an insurer or organization employed by an insurer who is engaging
1027 in the inspection, rating, or classification of risk, or the supervision of training of insurance
1028 producers; or

1029 (iii) an employee who counsels or advises the employee's employer with regard to the
1030 insurance interests of the employer, or a subsidiary or business affiliate of the employer[-]; and

1031 (f) an Indian health clinic or Urban Indian Health Center, as defined in Title V of the
1032 Indian Health Care Improvement Act, which assists a person with enrollment in a public
1033 program or an application for a premium subsidy.

1034 (3) The exemption from licensure under Subsections (2)(a) [~~and~~], (b), and (f) does not
1035 apply if a person described in Subsections (2)(a) [~~and~~], (b), and (f) enrolls a person in a private
1036 insurance plan.

1037 (4) The commissioner may by rule exempt a class of persons from the license
1038 requirement of Subsection 31A-23b-201(1) if:

1039 (a) the functions performed by the class of persons do not require:

1040 (i) special competence;

1041 (ii) special trustworthiness; or

1042 (iii) regulatory surveillance made possible by licensing; or

1043 (b) other existing safeguards make regulation unnecessary.

1044 Section 15. Section 31A-29-106 is amended to read:

1045 **31A-29-106. Powers of board.**

1046 (1) The board shall have the general powers and authority granted under the laws of
1047 this state to insurance companies licensed to transact health care insurance business. In
1048 addition, the board shall [~~have the specific authority to~~]:

1049 (a) have the specific authority to enter into contracts to carry out the provisions and
1050 purposes of this chapter, including, with the approval of the commissioner, contracts with:
1051 (i) similar pools of other states for the joint performance of common administrative
1052 functions; or
1053 (ii) persons or other organizations for the performance of administrative functions;
1054 (b) sue or be sued, including taking such legal action necessary to avoid the payment of
1055 improper claims against the pool or the coverage provided through the pool;
1056 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,
1057 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the
1058 operation of the pool;
1059 ~~[(d) issue policies of insurance in accordance with the requirements of this chapter;]~~
1060 (d) (i) close enrollment in the plans issued by the pool and cancel the plans issued by
1061 the pool in accordance with the plan of operation approved by the commissioner; and
1062 (ii) close out the business of the pool in accordance with the plan of operation,
1063 including processing and paying valid claims incurred by enrollees prior to the date enrollment
1064 is closed under Subsection (1)(d)(i);
1065 (e) retain an executive director and appropriate legal, actuarial, and other personnel as
1066 necessary to provide technical assistance in the operations of the pool and to close pool
1067 business in accordance with Subsection (1)(d);
1068 (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;
1069 (g) cause the pool to have an annual and a final audit of its operations by the state
1070 auditor;
1071 ~~[(h) coordinate with the Department of Health in seeking to obtain from the Centers for~~
1072 ~~Medicare and Medicaid Services, or other appropriate office or agency of government, all~~
1073 ~~appropriate waivers, authority, and permission needed to coordinate the coverage available~~
1074 ~~from the pool with coverage available under Medicaid, either before or after Medicaid~~
1075 ~~coverage, or as a conversion option upon completion of Medicaid eligibility, without the~~
1076 ~~necessity for requalification by the enrollee;]~~
1077 ~~[(i)]~~ (h) provide for and employ cost containment measures and requirements including
1078 preadmission certification, concurrent inpatient review, and individual case management for
1079 the purpose of making the pool more cost-effective;

1080 ~~[(j) offer pool coverage through contracts with health maintenance organizations,~~
1081 ~~preferred provider organizations, and other managed care systems that will manage costs while~~
1082 ~~maintaining quality care;]~~

1083 ~~[(k) (i) establish annual limits on benefits payable under the pool to or on behalf of~~
1084 ~~any enrollee;~~

1085 ~~[(h) (j) exclude from coverage under the pool specific benefits, medical conditions,~~
1086 ~~and procedures for the purpose of protecting the financial viability of the pool;~~

1087 ~~[(m) (k) administer the Pool Fund;~~

1088 ~~[(n) (l) make rules in accordance with Title 63G, Chapter 3, Utah Administrative~~
1089 ~~Rulemaking Act, to implement this chapter;~~

1090 ~~[(o) (m) adopt, trademark, and copyright a trade name for the pool for use in~~
1091 ~~marketing and publicizing the pool and its products; and~~

1092 ~~[(p) (n) transition health care coverage for all individuals covered under the pool as~~
1093 ~~part of the conversion to health insurance coverage, regardless of preexisting conditions, under~~
1094 ~~PPACA.~~

1095 (2) (a) The board shall prepare and submit an annual and final report to the Legislature
1096 which shall include:

1097 (i) the net premiums anticipated;

1098 (ii) actuarial projections of payments required of the pool;

1099 (iii) the expenses of administration; and

1100 (iv) the anticipated reserves or losses of the pool.

1101 (b) The budget for operation of the pool is subject to the approval of the board.

1102 (c) The administrative budget of the board and the commissioner under this chapter
1103 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
1104 subject to review and approval by the Legislature.

1105 ~~[(3)(a) The board shall on or before September 1, 2004, require the plan administrator~~
1106 ~~or an independent actuarial consultant retained by the plan administrator to redetermine the~~
1107 ~~reasonable equivalent of the criteria for uninsurability required under Subsection~~

1108 ~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]~~

1109 ~~[(b) The board shall redetermine the criteria established in Subsection (3)(a) at least~~
1110 ~~every five years thereafter.]~~

1111 Section 16. Section 31A-29-110 is amended to read:

1112 **31A-29-110. Pool administrator -- Selection -- Powers.**

1113 (1) The board shall select a pool administrator in accordance with Title 63G, Chapter
1114 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the
1115 board, which shall include:

- 1116 (a) ability to manage medical expenses;
- 1117 (b) proven ability to handle accident and health insurance;
- 1118 (c) efficiency of claim paying procedures;
- 1119 (d) marketing and underwriting;
- 1120 (e) proven ability for managed care and quality assurance;
- 1121 (f) provider contracting and discounts;
- 1122 (g) pharmacy benefit management;
- 1123 (h) an estimate of total charges for administering the pool; and
- 1124 (i) ability to administer the pool in a cost-efficient manner.

1125 (2) A pool administrator may be:

- 1126 (a) a health insurer;
- 1127 (b) a health maintenance organization;
- 1128 (c) a third-party administrator; or
- 1129 (d) any person or entity which has demonstrated ability to meet the criteria in

1130 Subsection (1).

1131 (3) ~~[(a)]~~ The pool administrator shall serve for a period of three years, with ~~[two~~
1132 ~~one-year]~~ yearly extension options until the operations of the pool are closed pursuant to
1133 Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract
1134 between the board and the administrator.

1135 ~~[(b) At least one year prior to the expiration of the contract between the board and the~~
1136 ~~pool administrator, the board shall invite all interested parties, including the current pool~~
1137 ~~administrator, to submit bids to serve as the pool administrator].~~

1138 ~~[(c) Selection of the pool administrator for a succeeding period shall be made at least~~
1139 ~~six months prior to the expiration of the period of service under Subsection (3)(a).]~~

1140 (4) The pool administrator is responsible for all operational functions of the pool and
1141 shall:

1142 (a) have access to all nonpatient specific experience data, statistics, treatment criteria,
1143 and guidelines compiled or adopted by the Medicaid program, the Public Employees Health
1144 Plan, the Department of Health, or the Insurance Department, and which are not otherwise
1145 declared by statute to be confidential;

1146 (b) perform all marketing, eligibility, enrollment, member agreements, and
1147 administrative claim payment functions relating to the pool;

1148 (c) establish, administer, and operate a monthly premium billing procedure for
1149 collection of premiums from enrollees;

1150 (d) perform all necessary functions to assure timely payment of benefits to enrollees,
1151 including:

1152 (i) making information available relating to the proper manner of submitting a claim
1153 for benefits to the pool administrator and distributing forms upon which submission shall be
1154 made; and

1155 (ii) evaluating the eligibility of each claim for payment by the pool;

1156 (e) submit regular reports to the board regarding the operation of the pool, the
1157 frequency, content, and form of which reports shall be determined by the board;

1158 (f) following the close of each calendar year, determine net written and earned
1159 premiums, the expense of administration, and the paid and incurred losses for the year and
1160 submit a report of this information to the board, the commissioner, and the Division of Finance
1161 on a form prescribed by the commissioner; and

1162 (g) be paid as provided in the plan of operation for expenses incurred in the
1163 performance of the pool administrator's services.

1164 Section 17. Section **31A-29-111** is amended to read:

1165 **31A-29-111. Eligibility -- Limitations.**

1166 (1) (a) Except as provided in Subsection (1)(b) and Subsection [31A-29-106\(1\)\(d\)](#), an
1167 individual who is not HIPAA eligible is eligible for pool coverage if the individual:

1168 (i) pays the established premium;

1169 (ii) is a resident of this state; and

1170 (iii) meets the health underwriting criteria under Subsection (5)(a).

1171 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not
1172 eligible for pool coverage if one or more of the following conditions apply:

- 1173 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
1174 except as provided in Section [31A-29-112](#);
- 1175 (ii) the individual has terminated coverage in the pool, unless:
1176 (A) 12 months have elapsed since the termination date; or
1177 (B) the individual demonstrates that creditable coverage has been involuntarily
1178 terminated for any reason other than nonpayment of premium;
- 1179 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
1180 (iv) the individual is an inmate of a public institution;
1181 (v) the individual is eligible for a public health plan, as defined in federal regulations
1182 adopted pursuant to 42 U.S.C. 300gg;
- 1183 (vi) the individual's health condition does not meet the criteria established under
1184 Subsection (5);
- 1185 (vii) the individual is eligible for coverage under an employer group that offers a health
1186 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members
1187 as:
- 1188 (A) an eligible employee;
1189 (B) a dependent of an eligible employee; or
1190 (C) a member;
- 1191 (viii) the individual is covered under any other health benefit plan;
1192 (ix) except as provided in Subsections (3) and (6), at the time of application, the
1193 individual has not resided in Utah for at least 12 consecutive months preceding the date of
1194 application; or
- 1195 (x) the individual's employer pays any part of the individual's health benefit plan
1196 premium, either as an insured or a dependent, for pool coverage.
- 1197 (2) (a) Except as provided in Subsection (2)(b) and Subsection [31A-29-106\(1\)\(d\)](#), an
1198 individual who is HIPAA eligible is eligible for pool coverage if the individual:
- 1199 (i) pays the established premium; and
1200 (ii) is a resident of this state.
- 1201 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for
1202 pool coverage if one or more of the following conditions apply:
1203 (i) the individual is eligible for health care benefits under Medicaid or Medicare,

1204 except as provided in Section 31A-29-112;

1205 (ii) the individual is eligible for a public health plan, as defined in federal regulations
1206 adopted pursuant to 42 U.S.C. 300gg;

1207 (iii) the individual is covered under any other health benefit plan;

1208 (iv) the individual is eligible for coverage under an employer group that offers a health
1209 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members
1210 as:

1211 (A) an eligible employee;

1212 (B) a dependent of an eligible employee; or

1213 (C) a member;

1214 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

1215 (vi) the individual is an inmate of a public institution; or

1216 (vii) the individual's employer pays any part of the individual's health benefit plan
1217 premium, either as an insured or a dependent, for pool coverage.

1218 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
1219 (1)(a), an individual whose health care insurance coverage from a state high risk pool with
1220 similar coverage is terminated because of nonresidency in another state is eligible for coverage
1221 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

1222 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the
1223 termination date of the previous high risk pool coverage.

1224 (c) The effective date of this state's pool coverage shall be the date of termination of
1225 the previous high risk pool coverage.

1226 (d) The waiting period of an individual with a preexisting condition applying for
1227 coverage under this chapter shall be waived:

1228 (i) to the extent to which the waiting period was satisfied under a similar plan from
1229 another state; and

1230 (ii) if the other state's benefit limitation was not reached.

1231 (4) (a) If an eligible individual applies for pool coverage within 30 days of being
1232 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
1233 than the first day of the month following the date of submission of the completed insurance
1234 application to the carrier.

1235 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
1236 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
1237 coverage.

1238 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
1239 based on:

1240 (i) health condition; and

1241 (ii) expected claims so that the expected claims are anticipated to remain within
1242 available funding.

1243 (b) The board, with approval of the commissioner, may contract with one or more
1244 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting
1245 criteria under Subsection (5)(a).

1246 (c) If an individual is denied coverage by the pool under the criteria established in
1247 Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage
1248 under ~~[Subsection]~~ Section 31A-30-108~~(3)~~.

1249 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
1250 (1)(a), an individual whose individual health care insurance coverage was involuntarily
1251 terminated, is eligible for coverage under the pool subject to the conditions of Subsections
1252 (1)(b)(i) through (viii) and (x).

1253 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the
1254 termination date of the previous individual health care insurance coverage.

1255 (c) The effective date of this state's pool coverage shall be the date of termination of
1256 the previous individual coverage.

1257 (d) The waiting period of an individual with a preexisting condition applying for
1258 coverage under this chapter shall be waived to the extent to which the waiting period was
1259 satisfied under the individual health insurance plan.

1260 Section 18. Section **31A-29-113** is amended to read:

1261 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**
1262 **conditions -- Waiver -- Maximum benefits.**

1263 (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished
1264 for the diagnoses or treatment of illness or injury that:

1265 (i) exceed the deductible and copayment amounts applicable under Section

1266 31A-29-114; and

1267 (ii) are not otherwise limited or excluded.

1268 (b) Eligible medical expenses are the allowed charges established by the board for the
1269 health care services and items rendered during times for which benefits are extended under the
1270 pool policy.

1271 (c) Section 31A-21-313 applies to coverage issued under this chapter.

1272 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and
1273 other limitations shall be established by the board.

1274 (3) The commissioner shall approve the benefit package developed by the board to
1275 ensure its compliance with this chapter.

1276 ~~[(4) The pool shall offer at least one benefit plan through a managed care program as~~
1277 ~~authorized under Section 31A-29-106.]~~

1278 ~~[(5)]~~ (4) This chapter may not be construed to prohibit the pool from issuing additional
1279 types of pool policies with different types of benefits which in the opinion of the board may be
1280 of benefit to the citizens of Utah.

1281 ~~[(6)]~~ (5) (a) The board shall design and require an administrator to employ cost
1282 containment measures and requirements including preadmission certification and concurrent
1283 inpatient review for the purpose of making the pool more cost effective.

1284 (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this
1285 chapter.

1286 ~~[(7)]~~ (6) (a) A pool policy may contain provisions under which coverage for a
1287 preexisting condition is excluded if:

1288 (i) the exclusion relates to a condition, regardless of the cause of the condition, for
1289 which medical advice, diagnosis, care, or treatment was recommended or received, from an
1290 individual licensed or similarly authorized to provide such services under state law and
1291 operating within the scope of practice authorized by state law, within the six-month period
1292 ending on the effective date of plan coverage; and

1293 (ii) except as provided in Subsection (8), the exclusion extends for a period no longer
1294 than the six-month period following the effective date of plan coverage for a given individual.

1295 (b) Subsection ~~[(7)]~~ (6)(a) does not apply to a HIPAA eligible individual.

1296 ~~[(8)]~~ (7) (a) A pool policy may contain provisions under which coverage for a

1297 preexisting pregnancy is excluded during a ten-month period following the effective date of
1298 plan coverage for a given individual.

1299 (b) Subsection [(8)] (7)(a) does not apply to a HIPAA eligible individual.

1300 [(9)] (8) (a) The pool will waive the preexisting condition exclusion described in
1301 Subsections [(7)] (6)(a) and [(8)] (7)(a) for an individual that is changing health coverage to the
1302 pool, to the extent to which similar exclusions have been satisfied under any prior health
1303 insurance coverage if the individual applies not later than 63 days following the date of
1304 involuntary termination, other than for nonpayment of premiums, from health coverage.

1305 (b) If this Subsection [(9)] (8) applies, coverage in the pool shall be effective from the
1306 date on which the prior coverage was terminated.

1307 [(10)] (9) Covered benefits available from the pool may not exceed a \$1,800,000
1308 lifetime maximum, which includes a per enrollee calendar year maximum established by the
1309 board.

1310 Section 19. Section **31A-29-114** is amended to read:

1311 **31A-29-114. Deductibles -- Copayments.**

1312 (1) (a) A pool policy shall impose a deductible on a per calendar year basis.

1313 (b) At least two deductible plans shall be offered.

1314 (c) The deductible is applied to all of the eligible medical expenses [~~as defined in~~
1315 ~~Section 31A-29-113;~~] incurred by the enrollee until the deductible has been satisfied. There
1316 are no benefits payable before the deductible has been satisfied.

1317 (d) The pool may offer separate deductibles for prescription benefits.

1318 (2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least
1319 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess
1320 of the mandatory deductible.

1321 (b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool
1322 policy.

1323 (3) The board shall establish maximum aggregate out-of-pocket payments for eligible
1324 medical expenses incurred by the enrollee for each of the deductible plans offered under
1325 Subsection (1)(b).

1326 (4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments
1327 under Subsection (3), the board may establish a coinsurance requirement to be imposed on

1328 eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

1329 (b) The circumstances in which the coinsurance authorized by this Subsection (4) may
1330 be imposed shall be designated in the pool policy.

1331 (c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to
1332 exceed 5% of eligible medical expenses.

1333 (5) The limits on maximum aggregate out-of-pocket payments for eligible medical
1334 expenses incurred by the enrollee under this section may not include out-of-pocket payments
1335 for prescription benefits.

1336 Section 20. Section **31A-29-115** is amended to read:

1337 **31A-29-115. Cancellation -- Notice.**

1338 (1) ~~[(a)]~~ On the date of renewal, the pool may cancel an enrollee's policy if:

1339 ~~[(i)]~~ (a) the enrollee's health condition does not meet the criteria established in
1340 Subsection **31A-29-111(5)**; and

1341 ~~[(ii)]~~ (b) the pool has provided written notice to the enrollee's last-known address no
1342 less than 60 days before cancellation~~[-and]~~.

1343 ~~[(iii)]~~ ~~at least one individual carrier has not reached the individual enrollment cap~~
1344 ~~established in Section **31A-30-110**.]~~

1345 ~~[(b)]~~ ~~The pool shall issue a certificate of insurability to an enrollee whose policy is~~
1346 ~~cancelled under Subsection (1)(a) for coverage under Subsection **31A-30-108(3)** if the~~
1347 ~~requirements of Subsection **31A-29-111(5)** are met.]~~

1348 (2) The pool may cancel an enrollee's policy at any time if:

1349 (a) the pool has provided written notice to the enrollee's last-known address no less
1350 than 15 days before cancellation; and

1351 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
1352 months;

1353 (ii) there is nonpayment of premiums; or

1354 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
1355 forth in Section **31A-29-111**, in which case:

1356 (A) the policy may be retroactively terminated for the period of time in which the
1357 enrollee was not eligible;

1358 (B) retroactive termination may not exceed three years; and

1359 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
1360 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection
1361 [31A-29-119\(3\)](#).

1362 Section 21. Section **31A-30-103** is amended to read:

1363 **31A-30-103. Definitions.**

1364 As used in this chapter:

1365 (1) "Actuarial certification" means a written statement by a member of the American
1366 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
1367 is in compliance with Sections [31A-30-106](#) and [31A-30-106.1](#), based upon the examination of
1368 the covered carrier, including review of the appropriate records and of the actuarial
1369 assumptions and methods used by the covered carrier in establishing premium rates for
1370 applicable health benefit plans.

1371 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
1372 through one or more intermediaries, controls or is controlled by, or is under common control
1373 with, a specified entity or person.

1374 (3) "Base premium rate" means, for each class of business as to a rating period, the
1375 lowest premium rate charged or that could have been charged under a rating system for that
1376 class of business by the covered carrier to covered insureds with similar case characteristics for
1377 health benefit plans with the same or similar coverage.

1378 (4) (a) "Bona fide employer association" means an association of employers:

1379 (i) that meets the requirements of Subsection [31A-22-701\(2\)\(b\)](#);

1380 (ii) in which the employers of the association, either directly or indirectly, exercise
1381 control over the plan;

1382 (iii) that is organized:

1383 (A) based on a commonality of interest between the employers and their employees
1384 that participate in the plan by some common economic or representation interest or genuine
1385 organizational relationship unrelated to the provision of benefits; and

1386 (B) to act in the best interests of its employers to provide benefits for the employer's
1387 employees and their spouses and dependents, and other benefits relating to employment; and

1388 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

1389 (b) The commissioner shall consider the following with regard to determining whether

1390 an association of employers is a bona fide employer association under Subsection (4)(a):

1391 (i) how association members are solicited;

1392 (ii) who participates in the association;

1393 (iii) the process by which the association was formed;

1394 (iv) the purposes for which the association was formed, and what, if any, were the
1395 pre-existing relationships of its members;

1396 (v) the powers, rights and privileges of employer members; and

1397 (vi) who actually controls and directs the activities and operations of the benefit
1398 programs.

1399 (5) "Carrier" means any person or entity that provides health insurance in this state
1400 including:

1401 (a) an insurance company;

1402 (b) a prepaid hospital or medical care plan;

1403 (c) a health maintenance organization;

1404 (d) a multiple employer welfare arrangement; and

1405 (e) any other person or entity providing a health insurance plan under this title.

1406 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
1407 demographic or other objective characteristics of a covered insured that are considered by the
1408 carrier in determining premium rates for the covered insured.

1409 (b) "Case characteristics" do not include:

1410 (i) duration of coverage since the policy was issued;

1411 (ii) claim experience; and

1412 (iii) health status.

1413 (7) "Class of business" means all or a separate grouping of covered insureds that is
1414 permitted by the commissioner in accordance with Section [31A-30-105](#).

1415 (8) "Conversion policy" means a policy providing coverage under the conversion
1416 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

1417 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
1418 this chapter.

1419 (10) "Covered individual" means any individual who is covered under a health benefit
1420 plan subject to this chapter.

1421 (11) "Covered insureds" means small employers and individuals who are issued a
1422 health benefit plan that is subject to this chapter.

1423 (12) "Dependent" means an individual to the extent that the individual is defined to be
1424 a dependent by:

1425 (a) the health benefit plan covering the covered individual; and

1426 (b) Chapter 22, Part 6, Accident and Health Insurance.

1427 (13) "Established geographic service area" means a geographical area approved by the
1428 commissioner within which the carrier is authorized to provide coverage.

1429 (14) "Index rate" means, for each class of business as to a rating period for covered
1430 insureds with similar case characteristics, the arithmetic average of the applicable base
1431 premium rate and the corresponding highest premium rate.

1432 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
1433 through a health benefit plan regardless of whether:

1434 (a) coverage is offered through:

1435 (i) an association;

1436 (ii) a trust;

1437 (iii) a discretionary group; or

1438 (iv) other similar groups; or

1439 (b) the policy or contract is situated out-of-state.

1440 (16) "Individual conversion policy" means a conversion policy issued to:

1441 (a) an individual; or

1442 (b) an individual with a family.

1443 (17) "Individual coverage count" means the number of natural persons covered under a
1444 carrier's health benefit products that are individual policies.

1445 (18) "Individual enrollment cap" means the percentage set by the commissioner in
1446 accordance with Section [31A-30-110](#).

1447 (19) "New business premium rate" means, for each class of business as to a rating
1448 period, the lowest premium rate charged or offered, or that could have been charged or offered,
1449 by the carrier to covered insureds with similar case characteristics for newly issued health
1450 benefit plans with the same or similar coverage.

1451 (20) "Premium" means money paid by covered insureds and covered individuals as a

1452 condition of receiving coverage from a covered carrier, including any fees or other
1453 contributions associated with the health benefit plan.

1454 (21) (a) "Rating period" means the calendar period for which premium rates
1455 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1456 (b) A covered carrier may not have:

1457 (i) more than one rating period in any calendar month; and

1458 (ii) no more than 12 rating periods in any calendar year.

1459 (22) "Resident" means an individual who has resided in this state for at least 12
1460 consecutive months immediately preceding the date of application.

1461 (23) "Short-term limited duration insurance" means a health benefit product that:

1462 (a) is not renewable; and

1463 (b) has an expiration date specified in the contract that is less than 364 days after the
1464 date the plan became effective.

1465 (24) "Small employer carrier" means a carrier that provides health benefit plans
1466 covering eligible employees of one or more small employers in this state, regardless of
1467 whether:

1468 (a) coverage is offered through:

1469 (i) an association;

1470 (ii) a trust;

1471 (iii) a discretionary group; or

1472 (iv) other similar grouping; or

1473 (b) the policy or contract is situated out-of-state.

1474 [~~(25) "Uninsurable" means an individual who:~~]

1475 [~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the
1476 underwriting criteria established in Subsection 31A-29-111(5); or]~~

1477 [~~(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and]~~

1478 [~~(ii) has a condition of health that does not meet consistently applied underwriting
1479 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g)
1480 and (h) for which coverage the applicant is applying.]~~

1481 [~~(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
1482 purposes of this formula:]~~

1483 ~~[(a) "CI" means the carrier's individual coverage count as of December 31 of the~~
1484 ~~preceding year; and]~~

1485 ~~[(b) "UC" means the number of uninsurable individuals who were issued an individual~~
1486 ~~policy on or after July 1, 1997.]~~

1487 Section 22. Section ~~31A-30-107~~ is amended to read:

1488 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
1489 **nonrenewal.**

1490 (1) Except as otherwise provided in this section, a small employer health benefit plan is
1491 renewable and continues in force:

1492 (a) with respect to all eligible employees and dependents; and

1493 (b) at the option of the plan sponsor.

1494 (2) A small employer health benefit plan may be discontinued or nonrenewed:

1495 (a) for a network plan, if ~~[(i)]~~ there is no longer any enrollee under the group health
1496 plan who lives, resides, or works in:

1497 ~~[(A)]~~ (i) the service area of the covered carrier; or

1498 ~~[(B)]~~ (ii) the area for which the covered carrier is authorized to do business; ~~[and] or~~

1499 ~~[(ii) in the case of the small employer market, the small employer carrier applies the~~
1500 ~~same criteria the small employer carrier would apply in denying enrollment in the plan under~~
1501 ~~Subsection ~~31A-30-108~~(7); or]~~

1502 (b) for coverage made available in the small or large employer market only through an
1503 association, if:

1504 (i) the employer's membership in the association ceases; and

1505 (ii) the coverage is terminated uniformly without regard to any health status-related
1506 factor relating to any covered individual.

1507 (3) A small employer health benefit plan may be discontinued if:

1508 (a) a condition described in Subsection (2) exists;

1509 (b) except as prohibited by Section ~~31A-30-206~~, the plan sponsor fails to pay
1510 premiums or contributions in accordance with the terms of the contract;

1511 (c) the plan sponsor:

1512 (i) performs an act or practice that constitutes fraud; or

1513 (ii) makes an intentional misrepresentation of material fact under the terms of the

1514 coverage;

1515 (d) the covered carrier:

1516 (i) elects to discontinue offering a particular small employer health benefit product

1517 delivered or issued for delivery in this state; and

1518 (ii) (A) provides notice of the discontinuation in writing:

1519 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1520 (II) at least 90 days before the date the coverage will be discontinued;

1521 (B) provides notice of the discontinuation in writing:

1522 (I) to the commissioner; and

1523 (II) at least three working days prior to the date the notice is sent to the affected plan

1524 sponsors, employees, and dependents of the plan sponsors or employees;

1525 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all

1526 other small employer health benefit products currently being offered by the small employer

1527 carrier in the market; and

1528 (D) in exercising the option to discontinue that product and in offering the option of

1529 coverage in this section, acts uniformly without regard to:

1530 (I) the claims experience of a plan sponsor;

1531 (II) any health status-related factor relating to any covered participant or beneficiary; or

1532 (III) any health status-related factor relating to any new participant or beneficiary who

1533 may become eligible for the coverage; or

1534 (e) the covered carrier:

1535 (i) elects to discontinue all of the covered carrier's small employer health benefit plans

1536 in:

1537 (A) the small employer market;

1538 (B) the large employer market; or

1539 (C) both the small employer and large employer markets; and

1540 (ii) (A) provides notice of the discontinuation in writing:

1541 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

1542 (II) at least 180 days before the date the coverage will be discontinued;

1543 (B) provides notice of the discontinuation in writing:

1544 (I) to the commissioner in each state in which an affected insured individual is known

1545 to reside; and

1546 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1547 sponsors, employees, and the dependents of the plan sponsors or employees;

1548 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1549 market; and

1550 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

1551 (4) A small employer health benefit plan may be discontinued or nonrenewed:

1552 (a) if a condition described in Subsection (2) exists; or

1553 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1554 employer contribution requirements.

1555 (5) A small employer health benefit plan may be nonrenewed:

1556 (a) if a condition described in Subsection (2) exists; or

1557 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1558 minimum participation requirements.

1559 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
1560 discontinued if after issuance of coverage the eligible employee:

1561 (i) engages in an act or practice that constitutes fraud in connection with the coverage;

1562 or

1563 (ii) makes an intentional misrepresentation of material fact in connection with the
1564 coverage.

1565 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

1566 (i) 12 months after the date of discontinuance; and

1567 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1568 to reenroll.

1569 (c) At the time the eligible employee's coverage is discontinued under Subsection
1570 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
1571 coverage is discontinued.

1572 (d) An eligible employee may not be discontinued under this Subsection (6) because of
1573 a fraud or misrepresentation that relates to health status.

1574 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
1575 the employer:

1576 (a) with respect to coverage provided to an employer member of the association; and

1577 (b) if the small employer health benefit plan is made available by a covered carrier in

1578 the employer market only through:

1579 (i) an association;

1580 (ii) a trust; or

1581 (iii) a discretionary group.

1582 (8) A covered carrier may modify a small employer health benefit plan only:

1583 (a) at the time of coverage renewal; and

1584 (b) if the modification is effective uniformly among all plans with that product.

1585 Section 23. Section **31A-30-108** is amended to read:

1586 **31A-30-108. Eligibility for small employer and individual market.**

1587 (1) (a) ~~[Small employer carriers shall accept residents]~~ A small employer carrier shall

1588 accept a small employer that applies for small group coverage as set forth in the Health

1589 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a) and PPACA, Sec. 2702.

1590 ~~[(b) Individual carriers shall accept residents for individual coverage pursuant to:]~~

1591 ~~[(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and]~~

1592 ~~[(ii) Subsection (3):]~~

1593 (b) An individual carrier shall accept an individual that applies for individual coverage

1594 as set forth in PPACA, Sec. 2702.

1595 (2) (a) ~~[Small]~~ A small employer ~~[carriers]~~ carrier shall offer to accept all eligible

1596 employees and their dependents at the same level of benefits under any health benefit plan

1597 provided to a small employer.

1598 (b) ~~[Small]~~ A small employer ~~[carriers]~~ carrier may:

1599 (i) request a small employer to submit a copy of the small employer's quarterly income

1600 tax withholdings to determine whether the employees for whom coverage is provided or

1601 requested are bona fide employees of the small employer; and

1602 (ii) deny or terminate coverage if the small employer refuses to provide documentation

1603 requested under Subsection (2)(b)(i).

1604 ~~[(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~

1605 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:]~~

1606 ~~[(a) the individual is not covered or eligible for coverage:]~~

1607 ~~[(i) (A) as an employee of an employer;]~~
1608 ~~[(B) as a member of an association; or]~~
1609 ~~[(C) as a member of any other group; and]~~
1610 ~~[(ii) under:]~~
1611 ~~[(A) a health benefit plan; or]~~
1612 ~~[(B) a self-insured arrangement that provides coverage similar to that provided by a~~
1613 ~~health benefit plan as defined in Section [31A-1-301](#);~~
1614 ~~[(b) the individual is not covered and is not eligible for coverage under any public~~
1615 ~~health benefits arrangement including:]~~
1616 ~~[(i) the Medicare program established under Title XVIII of the Social Security Act;]~~
1617 ~~[(ii) any act of Congress or law of this or any other state that provides benefits~~
1618 ~~comparable to the benefits provided under this chapter; or]~~
1619 ~~[(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter~~
1620 ~~29, Comprehensive Health Insurance Pool Act;]~~
1621 ~~[(c) unless the maximum benefit has been reached the individual is not covered or~~
1622 ~~eligible for coverage under any:]~~
1623 ~~[(i) Medicare supplement policy;]~~
1624 ~~[(ii) conversion option;]~~
1625 ~~[(iii) continuation or extension under COBRA; or]~~
1626 ~~[(iv) state extension;]~~
1627 ~~[(d) the individual has not terminated or declined coverage described in Subsection~~
1628 ~~(3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for~~
1629 ~~individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),~~
1630 ~~in which case, the requirement of this Subsection (3)(d) does not apply; and]~~
1631 ~~[(e) the individual is certified as ineligible for the Health Insurance Pool if:]~~
1632 ~~[(i) the individual applies for coverage with the Comprehensive Health Insurance Pool~~
1633 ~~within 30 days after being rejected or refused coverage by the covered carrier and reapplies for~~
1634 ~~coverage with that covered carrier within 30 days after the date of issuance of a certificate~~
1635 ~~under Subsection [31A-29-111\(5\)\(c\)](#); or]~~
1636 ~~[(ii) the individual applies for coverage with any individual carrier within 45 days~~
1637 ~~after:]~~

1638 ~~[(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or]~~
1639 ~~[(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the~~
1640 ~~individual applied first for coverage with the Comprehensive Health Insurance Pool.]~~
1641 ~~[(4) (a) If coverage is obtained under Subsection (3)(c)(i) and the required premium is~~
1642 ~~paid, the effective date of coverage shall be the first day of the month following the individual's~~
1643 ~~submission of a completed insurance application to that covered carrier.]~~
1644 ~~[(b) If coverage is obtained under Subsection (3)(c)(ii) and the required premium is~~
1645 ~~paid, the effective date of coverage shall be the day following the:]~~
1646 ~~[(i) cancellation of coverage under Subsection 31A-29-115(1); or]~~
1647 ~~[(ii) submission of a completed insurance application to the Comprehensive Health~~
1648 ~~Insurance Pool].~~
1649 ~~[(5) (a) An individual carrier is not required to accept individuals for coverage under~~
1650 ~~Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]~~
1651 ~~[(b) A carrier described in Subsection (5)(a) may not issue new individual policies in~~
1652 ~~the state for five years from July 1, 1997.]~~
1653 ~~[(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new~~
1654 ~~policies after July 1, 1999, which may only be granted if:]~~
1655 ~~[(i) the carrier accepts uninsurables as is required of a carrier entering the market under~~
1656 ~~Subsection 31A-30-110; and]~~
1657 ~~[(ii) the commissioner finds that the carrier's issuance of new individual policies:]~~
1658 ~~[(A) is in the best interests of the state; and]~~
1659 ~~[(B) does not provide an unfair advantage to the carrier.]~~
1660 ~~[(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29,~~
1661 ~~Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is~~
1662 ~~capped or suspended, an individual carrier may decline to accept individuals applying for~~
1663 ~~individual enrollment, other than individuals applying for coverage as set forth in Health~~
1664 ~~Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]~~
1665 ~~[(b) Within two calendar days of taking action under Subsection (6)(a), an individual~~
1666 ~~carrier will provide written notice to the department.]~~
1667 ~~[(7) (a) If a small employer carrier offers health benefit plans to small employers~~
1668 ~~through a network plan, the small employer carrier may:]~~

1669 ~~[(i) limit the employers that may apply for the coverage to those employers with~~
1670 ~~eligible employees who live, reside, or work in the service area for the network plan; and]~~
1671 ~~[(ii) within the service area of the network plan, deny coverage to an employer if the~~
1672 ~~small employer carrier has demonstrated to the commissioner that the small employer carrier:]~~
1673 ~~[(A) will not have the capacity to deliver services adequately to enrollees of any~~
1674 ~~additional groups because of the small employer carrier's obligations to existing group contract~~
1675 ~~holders and enrollees; and]~~
1676 ~~[(B) applies this section uniformly to all employers without regard to:]~~
1677 ~~[(f) the claims experience of an employer, an employer's employee, or a dependent of~~
1678 ~~an employee; or]~~
1679 ~~[(H) any health status-related factor relating to an employee or dependent of an~~
1680 ~~employee].~~
1681 ~~[(b) (i) A small employer carrier that denies a health benefit product to an employer in~~
1682 ~~any service area in accordance with this section may not offer coverage in the small employer~~
1683 ~~market within the service area to any employer for a period of 180 days after the date the~~
1684 ~~coverage is denied.]~~
1685 ~~[(ii) This Subsection (7)(b) does not:]~~
1686 ~~[(A) limit the small employer carrier's ability to renew coverage that is in force; or]~~
1687 ~~[(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~
1688 ~~force.]~~
1689 ~~[(c) Coverage offered within a service area after the 180-day period specified in~~
1690 ~~Subsection (7)(b) is subject to the requirements of this section.]~~
1691 Section 24. Section **31A-30-117** is amended to read:
1692 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**
1693 (1) (a) After complying with the reporting requirements of Section **63M-1-2505.5**, the
1694 commissioner may adopt administrative rules that change the rating and underwriting
1695 requirements of this chapter as necessary to transition the insurance market to meet federal
1696 qualified health plan standards and rating practices under PPACA.
1697 (b) Administrative rules adopted by the commissioner under this section may include:
1698 (i) the regulation of health benefit plans as described in Subsections **31A-2-212(5)(a)**
1699 and (b); and

1700 (ii) disclosure of records and information required by PPACA and state law.
1701 (c) (i) The commissioner shall establish by administrative rule one statewide open
1702 enrollment period that applies to the individual insurance market that is not on the PPACA
1703 certified individual exchange.
1704 (ii) The statewide open enrollment period:
1705 (A) may be shorter, but no longer than the open enrollment period established for the
1706 individual insurance market offered in the PPACA certified exchange; and
1707 (B) may not be extended beyond the dates of the open enrollment period established
1708 for the individual insurance market offered in the PPACA certified exchange.
1709 (2) A carrier that offers health benefit plans in the individual market that is not part of
1710 the individual PPACA certified exchange:
1711 (a) shall open enrollment:
1712 (i) during the statewide open enrollment period established in Subsection (1)(c); and
1713 (ii) at other times, for qualifying events, as determined by administrative rule adopted
1714 by the commissioner; and
1715 (b) may open enrollment at any time.
1716 ~~[(3) (a) The commissioner shall identify a new mandated benefit that is in excess of the~~
1717 ~~essential health benefits required by PPACA.]~~
1718 ~~[(b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to~~
1719 ~~defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c)~~
1720 ~~directly to the qualified health plan issuer on behalf of an individual who receives an advance~~
1721 ~~premium tax credit under PPACA.]~~
1722 ~~[(c) The state shall quantify the cost attributable to each additional mandated benefit~~
1723 ~~specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost~~
1724 ~~associated with the mandated benefit, which shall be:]~~
1725 ~~[(i) calculated in accordance with generally accepted actuarial principles and~~
1726 ~~methodologies;]~~
1727 ~~[(ii) conducted by a member of the American Academy of Actuaries; and]~~
1728 ~~[(iii) reported to the commissioner and to the individual exchange operating in the~~
1729 ~~state.]~~
1730 ~~[(d) The commissioner may require a proponent of a new mandated benefit under~~

1731 ~~Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance~~
1732 ~~with Subsection (3)(c). The commissioner may use the cost information provided under this~~
1733 ~~Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under~~
1734 ~~Subsection (3)(b).]~~

1735 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,
1736 or federal regulation, the commissioner shall allow a health insurer to choose to continue
1737 coverage and individuals and small employers to choose to re-enroll in coverage in
1738 nongrandfathered health coverage that is not in compliance with market reforms required by
1739 PPACA.

1740 Section 25. Section **31A-30-118** is enacted to read:

1741 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**
1742 **mandates -- Cost of additional benefits.**

1743 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the
1744 essential health benefits required by PPACA.

1745 (b) The state shall quantify the cost attributable to each additional mandated benefit
1746 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost
1747 associated with the mandated benefit, which shall be:

1748 (i) calculated in accordance with generally accepted actuarial principles and
1749 methodologies;

1750 (ii) conducted by a member of the American Academy of Actuaries; and

1751 (iii) reported to the commissioner and to the individual exchange operating in the state.

1752 (c) The commissioner may require a proponent of a new mandated benefit under
1753 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance
1754 with Subsection (1)(b). The commissioner may use the cost information provided under this
1755 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

1756 (2) If the state is required to defray the cost of additional required benefits under the
1757 provisions of 45 C.F.R. 155.170:

1758 (a) the state shall make the required payments:

1759 (i) in accordance with Subsection (3); and

1760 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

1761 (b) an issuer of a qualified health plan that receives a payment under the provisions of

1762 Subsection (1) and 45 C.F.R. 155.170 shall:

1763 (i) reduce the premium charged to the individual on whose behalf the issuer will be
1764 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection
1765 (1); or

1766 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an
1767 individual on whose behalf the issuer received a payment under Subsection (1), in an amount
1768 equal to the amount of the payment under Subsection (1); and

1769 (c) a premium rebate made under this section is not a prohibited inducement under
1770 Section 31A-23a-402.5.

1771 (3) A payment required under 45 C.F.R. 155.170(c) shall:

1772 (a) unless otherwise required by PPACA, be based on a statewide average of the cost
1773 of the additional benefit for all issuers who are entitled to payment under the provisions of 45
1774 C.F.R. 155.70; and

1775 (b) be submitted to an issuer through a process established and administered by:

1776 (i) the federal marketplace exchange for the state under PPACA for individual health
1777 plans; or

1778 (ii) Avenue H small employer market exchange for qualified health plans offered on
1779 the exchange.

1780 (4) The commissioner:

1781 (a) may adopt rules as necessary to administer the provisions of this section and 45
1782 C.F.R. 155.170; and

1783 (b) may not establish or implement the process for submitting the payments to an issuer
1784 under Subsection (3)(b)(i) unless the cost of establishing and implementing the process for
1785 submitting payments is paid for by the federal exchange marketplace.

1786 Section 26. Section **31A-30-301** is enacted to read:

1787 **Part 3. Individual and Small Employer Risk Adjustment Act**

1788 **31A-30-301. Title.**

1789 This part is known as the "Individual and Small Employer Risk Adjustment Act."

1790 Section 27. Section **31A-30-302** is enacted to read:

1791 **31A-30-302. Creation of state risk adjustment program.**

1792 (1) The commissioner shall convene a group of stakeholders and actuaries to assist the

1793 commissioner with the evaluation or the risk adjustment options described in Subsection (2). If
1794 the commissioner determines that a state-based risk adjustment program is in the best interest
1795 of the state, the commissioner shall establish an individual and small employer market risk
1796 adjustment program in accordance with 42 U.S.C. 18063 and this section.

1797 (2) The risk adjustment program adopted by the commissioner may include one of the
1798 following models:

1799 (a) continue the United States Department of Health and Human Services
1800 administration of the federal model for risk adjustment for the individual and small employer
1801 market in the state;

1802 (b) have the state administer the federal model for risk adjustment for the individual
1803 and small employer market in the state;

1804 (c) establish and operate a state based risk adjustment program for the individual and
1805 small employer market in the state; or

1806 (d) another risk adjustment model developed by the commissioner under Subsection
1807 (1).

1808 (3) Before adopting one of the models described in Subsection (2), the commissioner:

1809 (a) may enter into contracts to carry out the services needed to evaluate and establish
1810 one of the risk adjustment options described in Subsection (2); and

1811 (b) shall, prior to October 30, 2014, comply with the reporting requirements of Section
1812 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options
1813 described in Subsection (2).

1814 (4) The commissioner may:

1815 (a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah
1816 Administrative Rulemaking Act, that require an insurer that is subject to the state based risk
1817 adjustment program to submit data to the all payers claims database created under Section
1818 26-33a-106.1; and

1819 (b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act,
1820 to cover the ongoing administrative cost of running the state based risk adjustment program.

1821 Section 28. Section **31A-30-303** is enacted to read:

1822 **31A-30-303. Enterprise fund.**

1823 (1) There is created an enterprise fund known as the Individual and Small Employer

1824 Risk Adjustment Enterprise Fund.

1825 (2) The following funds shall be credited to the fund:

1826 (a) appropriations from the General Fund;

1827 (b) fees established by the commissioner under Section 31A-30-302;

1828 (c) risk adjustment payments received from insurers participating in the risk adjustment
1829 program; and

1830 (d) all interest and dividends earned on the fund's assets.

1831 (3) All money received by the fund shall be deposited in compliance with Section
1832 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51,
1833 Chapter 7, State Money Management Act.

1834 (4) The fund shall comply with the accounting policies, procedures, and reporting
1835 requirements established by the Division of Finance.

1836 (5) The fund shall comply with Title 63A, Utah Administrative Services Code.

1837 (6) The fund shall be used to implement and operate the risk adjustment program
1838 created by this part.

1839 Section 29. Section **63A-5-205** is amended to read:

1840 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**
1841 **coverage.**

1842 (1) As used in this section:

1843 (a) "Capital developments" has the same meaning as provided in Section 63A-5-104.

1844 (b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.

1845 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section
1846 34A-2-104 who:

1847 (i) works at least 30 hours per calendar week; and

1848 (ii) meets employer eligibility waiting requirements for health care insurance which
1849 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
1850 hire.

1851 (d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

1852 (e) "Qualified health insurance coverage" is as defined in Section 26-40-115.

1853 (f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

1854 (2) In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the director

1855 may:

1856 (a) subject to Subsection (3), enter into contracts for any work or professional services
1857 which the division or the State Building Board may do or have done; and

1858 (b) as a condition of any contract for architectural or engineering services, prohibit the
1859 architect or engineer from retaining a sales or agent engineer for the necessary design work.

1860 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design
1861 or construction contracts entered into by the division or the State Building Board on or after
1862 July 1, 2009, and:

1863 (i) applies to a prime contractor if the prime contract is in the amount of \$1,500,000 or
1864 greater; and

1865 (ii) applies to a subcontractor if the subcontract is in the amount of \$750,000 or greater.

1866 (b) This Subsection (3) does not apply:

1867 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

1868 (ii) if the contract is a sole source contract;

1869 (iii) if the contract is an emergency procurement; or

1870 (iv) to a change order as defined in Section [63G-6a-103](#), or a modification to a
1871 contract, when the contract does not meet the threshold required by Subsection (3)(a).

1872 (c) A person who intentionally uses change orders or contract modifications to
1873 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

1874 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that
1875 the contractor has and will maintain an offer of qualified health insurance coverage for the
1876 contractor's employees and the employees' dependents.

1877 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor
1878 shall demonstrate to the director that the subcontractor has and will maintain an offer of
1879 qualified health insurance coverage for the subcontractor's employees and the employees'
1880 dependents.

1881 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)
1882 during the duration of the contract is subject to penalties in accordance with administrative
1883 rules adopted by the division under Subsection (3)(f).

1884 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1885 requirements of Subsection (3)(d)(ii).

1886 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)
1887 during the duration of the contract is subject to penalties in accordance with administrative
1888 rules adopted by the division under Subsection (3)(f).

1889 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1890 requirements of Subsection (3)(d)(i).

1891 (f) The division shall adopt administrative rules:

1892 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1893 (ii) in coordination with:

1894 (A) the Department of Environmental Quality in accordance with Section 19-1-206;

1895 (B) the Department of Natural Resources in accordance with Section 79-2-404;

1896 (C) a public transit district in accordance with Section 17B-2a-818.5;

1897 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

1898 (E) the Department of Transportation in accordance with Section 72-6-107.5; and

1899 (F) the Legislature's Administrative Rules Review Committee; and

1900 (iii) which establish:

1901 (A) the requirements and procedures a contractor must follow to demonstrate to the
1902 director compliance with this Subsection (3) which shall include:

1903 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)
1904 or (ii) more than twice in any 12-month period; and

1905 (II) that the actuarially equivalent determination required for the qualified health
1906 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
1907 department or division with a written statement of actuarial equivalency from either:

1908 (Aa) the Utah Insurance Department;

1909 (Bb) an actuary selected by the contractor or the contractor's insurer; or

1910 (Cc) an underwriter who is responsible for developing the employer group's premium
1911 rates;

1912 (B) the penalties that may be imposed if a contractor or subcontractor intentionally
1913 violates the provisions of this Subsection (3), which may include:

1914 (I) a three-month suspension of the contractor or subcontractor from entering into
1915 future contracts with the state upon the first violation;

1916 (II) a six-month suspension of the contractor or subcontractor from entering into future

1917 contracts with the state upon the second violation;

1918 (III) an action for debarment of the contractor or subcontractor in accordance with
1919 Section [63G-6a-904](#) upon the third or subsequent violation; and

1920 (IV) monetary penalties which may not exceed 50% of the amount necessary to
1921 purchase qualified health insurance coverage for an employee and the dependents of an
1922 employee of the contractor or subcontractor who was not offered qualified health insurance
1923 coverage during the duration of the contract; and

1924 (C) a website on which the department shall post the benchmark for the qualified
1925 health insurance coverage identified in Subsection (1)(e).

1926 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or
1927 subcontractor who intentionally violates the provisions of this section shall be liable to the
1928 employee for health care costs that would have been covered by qualified health insurance
1929 coverage.

1930 (ii) An employer has an affirmative defense to a cause of action under Subsection
1931 (3)(g)(i) if:

1932 (A) the employer relied in good faith on a written statement of actuarial equivalency
1933 provided by:

1934 (I) an actuary; or

1935 (II) an underwriter who is responsible for developing the employer group's premium
1936 rates; or

1937 (B) the department determines that compliance with this section is not required under
1938 the provisions of Subsection (3)(b).

1939 (iii) An employee has a private right of action only against the employee's employer to
1940 enforce the provisions of this Subsection (3)(g).

1941 (h) Any penalties imposed and collected under this section shall be deposited into the
1942 Medicaid Restricted Account created by Section [26-18-402](#).

1943 (i) The failure of a contractor or subcontractor to provide qualified health insurance
1944 coverage as required by this section:

1945 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,
1946 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
1947 Procurement Code; and

1948 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or
1949 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
1950 or construction.

1951 (4) The judgment of the director as to the responsibility and qualifications of a bidder
1952 is conclusive, except in case of fraud or bad faith.

1953 (5) The division shall make all payments to the contractor for completed work in
1954 accordance with the contract and pay the interest specified in the contract on any payments that
1955 are late.

1956 (6) If any payment on a contract with a private contractor to do work for the division or
1957 the State Building Board is retained or withheld, it shall be retained or withheld and released as
1958 provided in Section 13-8-5.

1959 Section 30. Section 63C-9-403 is amended to read:

1960 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

1961 (1) For purposes of this section:

1962 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
1963 34A-2-104 who:

1964 (i) works at least 30 hours per calendar week; and

1965 (ii) meets employer eligibility waiting requirements for health care insurance which
1966 may not exceed the first of the calendar month following [90] 60 days from the date of hire.

1967 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

1968 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

1969 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

1970 (2) (a) Except as provided in Subsection (3), this section applies to a design or
1971 construction contract entered into by the board or on behalf of the board on or after July 1,
1972 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).

1973 (b) (i) A prime contractor is subject to this section if the prime contract is in the
1974 amount of \$1,500,000 or greater.

1975 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
1976 \$750,000 or greater.

1977 (3) This section does not apply if:

1978 (a) the application of this section jeopardizes the receipt of federal funds;

1979 (b) the contract is a sole source contract; or

1980 (c) the contract is an emergency procurement.

1981 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
1982 or a modification to a contract, when the contract does not meet the initial threshold required
1983 by Subsection (2).

1984 (b) A person who intentionally uses change orders or contract modifications to
1985 circumvent the requirements of Subsection (2) is guilty of an infraction.

1986 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
1987 director that the contractor has and will maintain an offer of qualified health insurance
1988 coverage for the contractor's employees and the employees' dependents during the duration of
1989 the contract.

1990 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
1991 shall demonstrate to the executive director that the subcontractor has and will maintain an offer
1992 of qualified health insurance coverage for the subcontractor's employees and the employees'
1993 dependents during the duration of the contract.

1994 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
1995 the duration of the contract is subject to penalties in accordance with administrative rules
1996 adopted by the division under Subsection (6).

1997 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1998 requirements of Subsection (5)(b).

1999 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2000 the duration of the contract is subject to penalties in accordance with administrative rules
2001 adopted by the department under Subsection (6).

2002 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2003 requirements of Subsection (5)(a).

2004 (6) The department shall adopt administrative rules:

2005 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2006 (b) in coordination with:

2007 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

2008 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

2009 (iii) the State Building Board in accordance with Section [63A-5-205](#);

2010 (iv) a public transit district in accordance with Section [17B-2a-818.5](#);

2011 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

2012 (vi) the Legislature's Administrative Rules Review Committee; and

2013 (c) which establish:

2014 (i) the requirements and procedures a contractor must follow to demonstrate to the

2015 executive director compliance with this section which shall include:

2016 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

2017 (b) more than twice in any 12-month period; and

2018 (B) that the actuarially equivalent determination required for the qualified health

2019 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the

2020 department or division with a written statement of actuarial equivalency from either:

2021 (I) the Utah Insurance Department;

2022 (II) an actuary selected by the contractor or the contractor's insurer; or

2023 (III) an underwriter who is responsible for developing the employer group's premium

2024 rates;

2025 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

2026 violates the provisions of this section, which may include:

2027 (A) a three-month suspension of the contractor or subcontractor from entering into

2028 future contracts with the state upon the first violation;

2029 (B) a six-month suspension of the contractor or subcontractor from entering into future

2030 contracts with the state upon the second violation;

2031 (C) an action for debarment of the contractor or subcontractor in accordance with

2032 Section [63G-6a-904](#) upon the third or subsequent violation; and

2033 (D) monetary penalties which may not exceed 50% of the amount necessary to

2034 purchase qualified health insurance coverage for employees and dependents of employees of

2035 the contractor or subcontractor who were not offered qualified health insurance coverage

2036 during the duration of the contract; and

2037 (iii) a website on which the department shall post the benchmark for the qualified

2038 health insurance coverage identified in Subsection (1)(c).

2039 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or

2040 subcontractor who intentionally violates the provisions of this section shall be liable to the

2041 employee for health care costs that would have been covered by qualified health insurance
2042 coverage.

2043 (ii) An employer has an affirmative defense to a cause of action under Subsection
2044 (7)(a)(i) if:

2045 (A) the employer relied in good faith on a written statement of actuarial equivalency
2046 provided by:

2047 (I) an actuary; or

2048 (II) an underwriter who is responsible for developing the employer group's premium
2049 rates; or

2050 (B) the department determines that compliance with this section is not required under
2051 the provisions of Subsection (3) or (4).

2052 (b) An employee has a private right of action only against the employee's employer to
2053 enforce the provisions of this Subsection (7).

2054 (8) Any penalties imposed and collected under this section shall be deposited into the
2055 Medicaid Restricted Account created in Section [26-18-402](#).

2056 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2057 coverage as required by this section:

2058 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2059 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
2060 Procurement Code; and

2061 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2062 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2063 or construction.

2064 Section 31. Section **63I-1-231 (Effective 07/01/14)** is amended to read:

2065 **63I-1-231 (Effective 07/01/14). Repeal dates, Title 31A.**

2066 (1) Section [31A-2-208.5](#), Comparison tables, is repealed July 1, 2015.

2067 (2) Section [31A-2-217](#), Coordination with other states, is repealed July 1, 2023.

2068 (3) Section [31A-22-619.6](#), Coordination of benefits with workers' compensation
2069 claim--Health insurer's duty to pay, is repealed on July 1, 2018.

2070 (4) Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is repealed July
2071 1, 2015.

2072 Section 32. Section **63M-1-2504** is amended to read:
2073 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
2074 (1) There is created within the Governor's Office of Economic Development the Office
2075 of Consumer Health Services.
2076 (2) The office shall:
2077 (a) in cooperation with the Insurance Department, the Department of Health, and the
2078 Department of Workforce Services, and in accordance with the electronic standards developed
2079 under Sections **31A-22-635** and **63M-1-2506**, create a Health Insurance Exchange that:
2080 (i) provides information to consumers about private and public health programs for
2081 which the consumer may qualify;
2082 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
2083 on the Health Insurance Exchange; and
2084 (iii) includes information and a link to enrollment in premium assistance programs and
2085 other government assistance programs;
2086 (b) contract with one or more private vendors for:
2087 (i) administration of the enrollment process on the Health Insurance Exchange,
2088 including establishing a mechanism for consumers to compare health benefit plan features on
2089 the exchange and filter the plans based on consumer preferences;
2090 (ii) the collection of health insurance premium payments made for a single policy by
2091 multiple payers, including the policyholder, one or more employers of one or more individuals
2092 covered by the policy, government programs, and others; and
2093 (iii) establishing a call center in accordance with Subsection ~~[(3)]~~ (4);
2094 (c) assist employers with a free or low cost method for establishing mechanisms for the
2095 purchase of health insurance by employees using pre-tax dollars;
2096 (d) establish a list on the Health Insurance Exchange of insurance producers who, in
2097 accordance with Section **31A-30-209**, are appointed producers for the Health Insurance
2098 Exchange; ~~[and]~~
2099 (e) submit, before November 1, an annual written report to the Business and Labor
2100 Interim Committee and the Health System Reform Task Force regarding the operations of the
2101 Health Insurance Exchange required by this chapter~~[-]; and~~
2102 (f) in accordance with Subsection (3), provide a form to a small employer that certifies:

- 2103 (i) that the small employer offered a qualified health plan to the small employer's
2104 employees; and
- 2105 (ii) the period of time within the taxable year in which the small employer maintained
2106 the qualified health plan coverage.
- 2107 (3) The form required by Subsection (2)(f) shall be provided to a small employer if:
- 2108 (a) the small employer selected a qualified health plan on the small employer health
2109 exchange created by this section; or
- 2110 (b) (i) the small employer selected a health plan in the small employer market that is
2111 not offered through the exchange created by this section; and
- 2112 (ii) the issuer of the health plan selected by the small employer submits to the office, in
2113 a form and manner required by the office:
- 2114 (A) an affidavit from a member of the American Academy of Actuaries stating that
2115 based on generally accepted actuarial principles and methodologies the issuer's health plan
2116 meets the benefit and actuarial requirements for a qualified health plan under PPACA as
2117 defined in Section 31A-1-301; and
- 2118 (B) an affidavit from the issuer that includes the dates of coverage for the small
2119 employer during the taxable year.
- 2120 [~~3~~] (4) A call center established by the office:
- 2121 (a) shall provide unbiased answers to questions concerning exchange operations, and
2122 plan information, to the extent the plan information is posted on the exchange by the insurer;
2123 and
- 2124 (b) may not:
- 2125 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;
2126 (ii) receive producer compensation through the Health Insurance Exchange; and
2127 (iii) be designated as the default producer for an employer group that enters the Health
2128 Insurance Exchange without a producer.
- 2129 [~~4~~] (5) The office:
- 2130 (a) may not:
- 2131 (i) regulate health insurers, health insurance plans, health insurance producers, or
2132 health insurance premiums charged in the exchange;
- 2133 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

2134 (iii) act as an appeals entity for resolving disputes between a health insurer and an
2135 insured;

2136 (b) may establish and collect a fee for the cost of the exchange transaction in
2137 accordance with Section 63J-1-504 for:

2138 (i) processing an application for a health benefit plan;

2139 (ii) accepting, processing, and submitting multiple premium payment sources;

2140 (iii) providing a mechanism for consumers to filter and compare health benefit plans in
2141 the exchange based on consumer preferences; and

2142 (iv) funding the call center; and

2143 (c) shall separately itemize the fee established under Subsection [~~(4)~~] (5)(b) as part of
2144 the cost displayed for the employer selecting coverage on the exchange.

2145 Section 33. Section 72-6-107.5 is amended to read:

2146 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**
2147 **insurance coverage.**

2148 (1) For purposes of this section:

2149 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2150 34A-2-104 who:

2151 (i) works at least 30 hours per calendar week; and

2152 (ii) meets employer eligibility waiting requirements for health care insurance which
2153 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
2154 hire.

2155 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2156 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

2157 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2158 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered
2159 into by the department on or after July 1, 2009, for construction or design of highways and to a
2160 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

2161 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2162 amount of \$1,500,000 or greater.

2163 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2164 \$750,000 or greater.

- 2165 (3) This section does not apply if:
- 2166 (a) the application of this section jeopardizes the receipt of federal funds;
- 2167 (b) the contract is a sole source contract; or
- 2168 (c) the contract is an emergency procurement.
- 2169 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
- 2170 or a modification to a contract, when the contract does not meet the initial threshold required
- 2171 by Subsection (2).
- 2172 (b) A person who intentionally uses change orders or contract modifications to
- 2173 circumvent the requirements of Subsection (2) is guilty of an infraction.
- 2174 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
- 2175 the contractor has and will maintain an offer of qualified health insurance coverage for the
- 2176 contractor's employees and the employees' dependents during the duration of the contract.
- 2177 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
- 2178 demonstrate to the department that the subcontractor has and will maintain an offer of qualified
- 2179 health insurance coverage for the subcontractor's employees and the employees' dependents
- 2180 during the duration of the contract.
- 2181 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
- 2182 the duration of the contract is subject to penalties in accordance with administrative rules
- 2183 adopted by the department under Subsection (6).
- 2184 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
- 2185 requirements of Subsection (5)(b).
- 2186 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
- 2187 the duration of the contract is subject to penalties in accordance with administrative rules
- 2188 adopted by the department under Subsection (6).
- 2189 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
- 2190 requirements of Subsection (5)(a).
- 2191 (6) The department shall adopt administrative rules:
- 2192 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
- 2193 (b) in coordination with:
- 2194 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);
- 2195 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

- 2196 (iii) the State Building Board in accordance with Section [63A-5-205](#);
- 2197 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);
- 2198 (v) a public transit district in accordance with Section [17B-2a-818.5](#); and
- 2199 (vi) the Legislature's Administrative Rules Review Committee; and
- 2200 (c) which establish:
 - 2201 (i) the requirements and procedures a contractor must follow to demonstrate to the
 - 2202 department compliance with this section which shall include:
 - 2203 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
 - 2204 (b) more than twice in any 12-month period; and
 - 2205 (B) that the actuarially equivalent determination required for qualified health insurance
 - 2206 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
 - 2207 division with a written statement of actuarial equivalency from either:
 - 2208 (I) the Utah Insurance Department;
 - 2209 (II) an actuary selected by the contractor or the contractor's insurer; or
 - 2210 (III) an underwriter who is responsible for developing the employer group's premium
 - 2211 rates;
 - 2212 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
 - 2213 violates the provisions of this section, which may include:
 - 2214 (A) a three-month suspension of the contractor or subcontractor from entering into
 - 2215 future contracts with the state upon the first violation;
 - 2216 (B) a six-month suspension of the contractor or subcontractor from entering into future
 - 2217 contracts with the state upon the second violation;
 - 2218 (C) an action for debarment of the contractor or subcontractor in accordance with
 - 2219 Section [63G-6a-904](#) upon the third or subsequent violation; and
 - 2220 (D) monetary penalties which may not exceed 50% of the amount necessary to
 - 2221 purchase qualified health insurance coverage for an employee and a dependent of the employee
 - 2222 of the contractor or subcontractor who was not offered qualified health insurance coverage
 - 2223 during the duration of the contract; and
 - 2224 (iii) a website on which the department shall post the benchmark for the qualified
 - 2225 health insurance coverage identified in Subsection (1)(c).
 - 2226 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or

2227 subcontractor who intentionally violates the provisions of this section shall be liable to the
2228 employee for health care costs that would have been covered by qualified health insurance
2229 coverage.

2230 (ii) An employer has an affirmative defense to a cause of action under Subsection
2231 (7)(a)(i) if:

2232 (A) the employer relied in good faith on a written statement of actuarial equivalency
2233 provided by:

2234 (I) an actuary; or

2235 (II) an underwriter who is responsible for developing the employer group's premium
2236 rates; or

2237 (B) the department determines that compliance with this section is not required under
2238 the provisions of Subsection (3) or (4).

2239 (b) An employee has a private right of action only against the employee's employer to
2240 enforce the provisions of this Subsection (7).

2241 (8) Any penalties imposed and collected under this section shall be deposited into the
2242 Medicaid Restricted Account created in Section [26-18-402](#).

2243 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2244 coverage as required by this section:

2245 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2246 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
2247 Procurement Code; and

2248 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2249 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2250 or construction.

2251 Section 34. Section **79-2-404** is amended to read:

2252 **79-2-404. Contracting powers of department -- Health insurance coverage.**

2253 (1) For purposes of this section:

2254 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2255 [34A-2-104](#) who:

2256 (i) works at least 30 hours per calendar week; and

2257 (ii) meets employer eligibility waiting requirements for health care insurance which

2258 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
2259 hire.

2260 (b) "Health benefit plan" has the same meaning as provided in Section [31A-1-301](#).

2261 (c) "Qualified health insurance coverage" is as defined in Section [26-40-115](#).

2262 (d) "Subcontractor" has the same meaning provided for in Section [63A-5-208](#).

2263 (2) (a) Except as provided in Subsection (3), this section applies a design or
2264 construction contract entered into by, or delegated to, the department or a division, board, or
2265 council of the department on or after July 1, 2009, and to a prime contractor or to a
2266 subcontractor in accordance with Subsection (2)(b).

2267 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2268 amount of \$1,500,000 or greater.

2269 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2270 \$750,000 or greater.

2271 (3) This section does not apply to contracts entered into by the department or a
2272 division, board, or council of the department if:

2273 (a) the application of this section jeopardizes the receipt of federal funds;

2274 (b) the contract or agreement is between:

2275 (i) the department or a division, board, or council of the department; and

2276 (ii) (A) another agency of the state;

2277 (B) the federal government;

2278 (C) another state;

2279 (D) an interstate agency;

2280 (E) a political subdivision of this state; or

2281 (F) a political subdivision of another state; or

2282 (c) the contract or agreement is:

2283 (i) for the purpose of disbursing grants or loans authorized by statute;

2284 (ii) a sole source contract; or

2285 (iii) an emergency procurement.

2286 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
2287 or a modification to a contract, when the contract does not meet the initial threshold required
2288 by Subsection (2).

2289 (b) A person who intentionally uses change orders or contract modifications to
2290 circumvent the requirements of Subsection (2) is guilty of an infraction.

2291 (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department
2292 that the contractor has and will maintain an offer of qualified health insurance coverage for the
2293 contractor's employees and the employees' dependents during the duration of the contract.

2294 (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor
2295 shall demonstrate to the department that the subcontractor has and will maintain an offer of
2296 qualified health insurance coverage for the subcontractor's employees and the employees'
2297 dependents during the duration of the contract.

2298 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2299 the duration of the contract is subject to penalties in accordance with administrative rules
2300 adopted by the department under Subsection (6).

2301 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2302 requirements of Subsection (5)(b).

2303 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2304 the duration of the contract is subject to penalties in accordance with administrative rules
2305 adopted by the department under Subsection (6).

2306 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2307 requirements of Subsection (5)(a).

2308 (6) The department shall adopt administrative rules:

2309 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2310 (b) in coordination with:

2311 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

2312 (ii) a public transit district in accordance with Section [17B-2a-818.5](#);

2313 (iii) the State Building Board in accordance with Section [63A-5-205](#);

2314 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

2315 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and

2316 (vi) the Legislature's Administrative Rules Review Committee; and

2317 (c) which establish:

2318 (i) the requirements and procedures a contractor must follow to demonstrate

2319 compliance with this section to the department which shall include:

2320 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2321 (b) more than twice in any 12-month period; and

2322 (B) that the actuarially equivalent determination required for qualified health insurance
2323 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2324 division with a written statement of actuarial equivalency from either:

2325 (I) the Utah Insurance Department;

2326 (II) an actuary selected by the contractor or the contractor's insurer; or

2327 (III) an underwriter who is responsible for developing the employer group's premium
2328 rates;

2329 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2330 violates the provisions of this section, which may include:

2331 (A) a three-month suspension of the contractor or subcontractor from entering into
2332 future contracts with the state upon the first violation;

2333 (B) a six-month suspension of the contractor or subcontractor from entering into future
2334 contracts with the state upon the second violation;

2335 (C) an action for debarment of the contractor or subcontractor in accordance with
2336 Section [63G-6a-904](#) upon the third or subsequent violation; and

2337 (D) monetary penalties which may not exceed 50% of the amount necessary to
2338 purchase qualified health insurance coverage for an employee and a dependent of an employee
2339 of the contractor or subcontractor who was not offered qualified health insurance coverage
2340 during the duration of the contract; and

2341 (iii) a website on which the department shall post the benchmark for the qualified
2342 health insurance coverage identified in Subsection (1)(c).

2343 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2344 subcontractor who intentionally violates the provisions of this section shall be liable to the
2345 employee for health care costs that would have been covered by qualified health insurance
2346 coverage.

2347 (ii) An employer has an affirmative defense to a cause of action under Subsection
2348 (7)(a)(i) if:

2349 (A) the employer relied in good faith on a written statement of actuarial equivalency
2350 provided by:

2351 (I) an actuary; or
2352 (II) an underwriter who is responsible for developing the employer group's premium
2353 rates; or

2354 (B) the department determines that compliance with this section is not required under
2355 the provisions of Subsection (3) or (4).

2356 (b) An employee has a private right of action only against the employee's employer to
2357 enforce the provisions of this Subsection (7).

2358 (8) Any penalties imposed and collected under this section shall be deposited into the
2359 Medicaid Restricted Account created in Section [26-18-402](#).

2360 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2361 coverage as required by this section:

2362 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2363 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
2364 Procurement Code; and

2365 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2366 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2367 or construction.

2368 Section 35. **Effective date.**

2369 (1) Except as provided in Subsection (2), this bill takes effect May 13, 2014.

2370 (2) The amendments to Section [63I-1-231](#) (Effective 07/01/14) take effect on July 1,
2371 2014.

2372 Section 36. **Coordinating H.B. 141 with H.B. 24 -- Superseding technical and**
2373 **substantive amendments.**

2374 If this H.B. 141 and H.B. 24, Insurance Related Amendments, both pass and become
2375 law, it is the intent of the Legislature that the amendments to Sections [31A-23b-205](#) and
2376 [31A-23b-206](#) in this bill, supersede the amendments to Sections [31A-23b-205](#) and
2377 [31A-23b-206](#) in H.B. 24, when the Office of Legislative Research and General Counsel
2378 prepares the Utah Code database for publication.

2379 Section 37. **Coordinating H.B. 141 with H.B. 35 -- Superseding technical and**
2380 **substantive amendments.**

2381 If this H.B. 141 and H.B. 35, Reauthorization of Health Data Authority Act, both pass

2382 and become law, it is the intent of the Legislature that the amendments to Section [26-33a-106.1](#)
2383 in this bill, supersede the amendments to Section [26-33a-106.1](#) in H.B. 35, when the Office of
2384 Legislative Research and General Counsel prepares the Utah Code database for publication.