

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



- 28 ▶ creates the Individual and Small Employer Risk Adjustment Act, which:
- 29 • requires the insurance commissioner to work with stakeholders to develop a
- 30 state based risk adjustment program for the individual and small group market;
- 31 • describes the risk adjustment models the commissioner may consider;
- 32 • requires the commissioner to report to the Legislature before implementing a
- 33 risk adjustment model;
- 34 • authorizes the commissioner to set fees for the operation of the risk adjustment
- 35 program; and
- 36 • establishes an Individual and Small Employer Risk Adjustment Enterprise Fund
- 37 for the operation of the program;
- 38 ▶ requires the Office of Consumer Health Services, which runs the small employer
- 39 health insurance exchange, to provide the form required for the federal small
- 40 employer premium tax credit to small employers who purchase qualified health
- 41 plans; and
- 42 ▶ makes technical and conforming amendments.

43 **Money Appropriated in this Bill:**

44 None

45 **Other Special Clauses:**

46 This bill provides an effective date.

47 **Utah Code Sections Affected:**

48 AMENDS:

- 49 17B-2a-818.5, as last amended by Laws of Utah 2012, Chapter 347
- 50 19-1-206, as last amended by Laws of Utah 2012, Chapter 347
- 51 26-33a-106.1, as last amended by Laws of Utah 2012, Chapter 279
- 52 26-33a-106.5, as last amended by Laws of Utah 2012, Chapter 279
- 53 26-33a-109, as last amended by Laws of Utah 2010, Chapter 68
- 54 31A-4-115, as last amended by Laws of Utah 2002, Chapter 308
- 55 31A-8-402.3, as last amended by Laws of Utah 2004, Chapter 329
- 56 31A-22-721, as last amended by Laws of Utah 2011, Chapter 284
- 57 31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341
- 58 31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341

- 59 **31A-23b-211**, as enacted by Laws of Utah 2013, Chapter 341
- 60 **31A-29-106**, as last amended by Laws of Utah 2013, Chapter 319
- 61 **31A-29-110**, as last amended by Laws of Utah 2012, Chapter 347
- 62 **31A-29-111**, as last amended by Laws of Utah 2012, Chapters 158 and 347
- 63 **31A-29-113**, as last amended by Laws of Utah 2013, Chapter 319
- 64 **31A-29-114**, as last amended by Laws of Utah 2006, Chapter 95
- 65 **31A-29-115**, as last amended by Laws of Utah 2004, Chapter 2
- 66 **31A-30-103**, as last amended by Laws of Utah 2013, Chapter 168
- 67 **31A-30-107**, as last amended by Laws of Utah 2009, Chapter 12
- 68 **31A-30-108**, as last amended by Laws of Utah 2011, Chapter 284
- 69 **31A-30-117**, as enacted by Laws of Utah 2013, Chapter 341
- 70 **63A-5-205**, as last amended by Laws of Utah 2012, Chapter 347
- 71 **63C-9-403**, as last amended by Laws of Utah 2012, Chapter 347
- 72 **63I-1-231 (Effective 07/01/14)**, as last amended by Laws of Utah 2013, Chapters 261
- 73 and 417
- 74 **63M-1-2504**, as last amended by Laws of Utah 2013, Chapter 255
- 75 **72-6-107.5**, as last amended by Laws of Utah 2012, Chapter 347
- 76 **79-2-404**, as last amended by Laws of Utah 2012, Chapter 347

77 ENACTS:

- 78 **31A-23b-202.5**, Utah Code Annotated 1953
- 79 **31A-30-118**, Utah Code Annotated 1953
- 80 **31A-30-301**, Utah Code Annotated 1953
- 81 **31A-30-302**, Utah Code Annotated 1953
- 82 **31A-30-303**, Utah Code Annotated 1953

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

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

86 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**
87 **coverage.**

88 (1) For purposes of this section:

89 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section

90 34A-2-104 who:

91 (i) works at least 30 hours per calendar week; and
92 (ii) meets employer eligibility waiting requirements for health care insurance which
93 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
94 hire.

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

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

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

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

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

103 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
104 \$750,000 or greater.

105 (3) This section does not apply if:

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

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

108 (c) the contract is an emergency procurement.

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

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

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

118 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
119 shall demonstrate to the public transit district that the subcontractor has and will maintain an
120 offer of qualified health insurance coverage for the subcontractor's employees and the

121 employee's dependents during the duration of the contract.

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

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

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

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

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

133 (a) in coordination with:

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

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

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

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

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

139 (b) which establish:

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

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

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

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

147 (I) the Utah Insurance Department;

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

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

151 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

152 violates the provisions of this section, which may include:

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

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

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

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

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

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

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

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

173 (I) actuary; or

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

175 or

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

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

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

182 (9) The failure of a contractor or subcontractor to provide qualified health insurance

183 coverage as required by this section:

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

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

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

191 **19-1-206. Contracting powers of department -- Health insurance coverage.**

192 (1) For purposes of this section:

193 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
194 [34A-2-104](#) who:

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

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

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

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

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

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

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

208 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
209 \$750,000 or greater.

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

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

213 (b) the contract or agreement is between:

- 214 (i) the department or a division or board of the department; and
- 215 (ii) (A) another agency of the state;
- 216 (B) the federal government;
- 217 (C) another state;
- 218 (D) an interstate agency;
- 219 (E) a political subdivision of this state; or
- 220 (F) a political subdivision of another state;
- 221 (c) the executive director determines that applying the requirements of this section to a
- 222 particular contract interferes with the effective response to an immediate health and safety
- 223 threat from the environment; or
- 224 (d) the contract is:
 - 225 (i) a sole source contract; or
 - 226 (ii) an emergency procurement.
- 227 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
- 228 or a modification to a contract, when the contract does not meet the initial threshold required
- 229 by Subsection (2).
- 230 (b) A person who intentionally uses change orders or contract modifications to
- 231 circumvent the requirements of Subsection (2) is guilty of an infraction.
- 232 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
- 233 director that the contractor has and will maintain an offer of qualified health insurance
- 234 coverage for the contractor's employees and the employees' dependents during the duration of
- 235 the contract.
- 236 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
- 237 demonstrate to the executive director that the subcontractor has and will maintain an offer of
- 238 qualified health insurance coverage for the subcontractor's employees and the employees'
- 239 dependents during the duration of the contract.
- 240 (c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration
- 241 of the contract is subject to penalties in accordance with administrative rules adopted by the
- 242 department under Subsection (6).
- 243 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
- 244 requirements of Subsection (5)(b).

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

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

250 (6) The department shall adopt administrative rules:

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

252 (b) in coordination with:

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

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

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

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

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

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

259 (c) which establish:

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

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

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

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

267 (I) the Utah Insurance Department;

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

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

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

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

275 (B) a six-month suspension of the contractor or subcontractor from entering into future

276 contracts with the state upon the second violation;

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

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

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

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

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

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

293 (I) an actuary; or

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

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

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

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

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

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

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

310 Section 3. Section **26-33a-106.1** is amended to read:

311 **26-33a-106.1. Health care cost and reimbursement data.**

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

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

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

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

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

320 [~~(iv) a physician from a small group practice as designated by the Utah Medical~~
321 ~~Association;]~~

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

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

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

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

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

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

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

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

333 [~~(i)] (a) establish a plan for collecting data from data suppliers, as defined in Section~~

334 [26-33a-102](#), to determine measurements of cost and reimbursements for risk adjusted episodes

335 of health care;

336 [~~(ii)] (b) share data regarding insurance claims and an individual's and small employer~~

337 group's health risk factor with [~~insurers participating in the defined contribution market created~~

338 in Title 31A, Chapter 30, Part 2, ~~Defined Contribution Arrangements~~] the Insurance
339 Department, only to the extent necessary for[:] risk adjusting; and
340 [~~(A)~~] ~~establishing rates and prospective risk adjusting in the defined contribution~~
341 ~~arrangement market; and~~
342 [~~(B)~~] ~~risk adjusting in the defined contribution arrangement market; and~~
343 [~~(iii)~~] (c) assist the Legislature and the public with awareness of, and the promotion of,
344 transparency in the health care market by reporting on:
345 [~~(A)~~] (i) geographic variances in medical care and costs as demonstrated by data
346 available to the committee; [~~and~~]
347 [~~(B)~~] (ii) rate and price increases by health care providers:
348 [~~(1)~~] (A) that exceed the Consumer Price Index - Medical as provided by the United
349 States Bureau of Labor statistics;
350 [~~(2)~~] (B) as calculated yearly from June to June; and
351 [~~(3)~~] (C) as demonstrated by data available to the committee[:]; and
352 (iii) on at least a monthly basis, provide data collected by the committee to a
353 not-for-profit, broad based coalition of state health care insurers and health care providers that
354 are involved in the standardized electronic exchange of health data, to the extent necessary:
355 (A) for the department or the Medicaid Office of the Inspector General to determine
356 insurance enrollment of an individual;
357 (B) for an insurer that is a data supplier to determine insurance enrollment of an
358 individual for the purpose of coordination of health care benefits;
359 (C) for a health care provider to determine insurance enrollment for a patient for the
360 purpose of claims submission by the health care provider; and
361 (D) to the Insurance Department for the purpose of transparency in the health care
362 market and risk adjusting under Subsection (1)(b).
363 [~~(b)~~] (2) The plan adopted under [~~this~~] Subsection [~~(2)~~] (1) shall include:
364 [~~(i)~~] (a) the type of data that will be collected;
365 [~~(ii)~~] (b) how the data will be evaluated;
366 [~~(iii)~~] (c) how the data will be used;
367 [~~(iv)~~] (d) the extent to which, and how the data will be protected; and
368 [~~(v)~~] (e) who will have access to the data.

369 Section 4. Section **26-33a-106.5** is amended to read:

370 **26-33a-106.5. Comparative analyses.**

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

374 (2) (a) [~~The~~] Except as provided in Subsection (7)(c), the committee shall publish
375 compilations or reports from the data it collects under this chapter or from any other source
376 which:

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

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

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

382 (i) be published at least annually; and

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

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

385 (B) charges; and

386 (C) nationally recognized patient safety standards.

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

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

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

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

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

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

403 (i) routine and preventive care; and

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

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

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

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

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

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

417 (c) The department:

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

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

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

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

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

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

430 (7) (a) The Health Data Committee shall, through the department, for purposes of

431 Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral,
432 non-biased entity with a broad base of support from health care payers and health care
433 providers.

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

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

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

445 Section 5. Section **26-33a-109** is amended to read:

446 **26-33a-109. Exceptions to prohibition on disclosure of identifiable health data.**

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

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

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

450 (i) this section[-];

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

452 26-33a-104(1)(b); or

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

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

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

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

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

461 (a) be for a specified period; or

462 (b) be solely for bona fide research and statistical purposes as determined in
463 accordance with administrative rules adopted by the department, which shall require:
464 (i) the requesting entity to demonstrate to the department that the data is required for
465 the research and statistical purposes proposed by the requesting entity; and
466 (ii) the requesting entity to enter into a written agreement satisfactory to the department
467 to protect the data in accordance with this chapter or other applicable law.

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

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

472 Section 6. Section 31A-4-115 is amended to read:

473 **31A-4-115. Plan of orderly withdrawal.**

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

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

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

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

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

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

488 Insurance Pool if:

- 489 (I) the insurer is an accident and health insurer; and
- 490 (II) the insurer's line of business is not assumed or placed with another insurer

491 approved by the commissioner; or

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

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

494 (II) the insurer's line of business is not assumed or placed with another insurer

495 approved by the commissioner.

496 (3) The commissioner shall approve a plan of orderly withdrawal if the plan adequately

497 demonstrates that the insurer will:

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

499 (b) meet the insurer's contractual obligations;

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

501 (d) meet any applicable statutory obligations.

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

503 orderly withdrawal.

504 (5) The commissioner may require an insurer to increase the deposit maintained in

505 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in

506 the name of the commissioner upon finding, after an adjudicative proceeding that:

507 (a) there is reasonable cause to conclude that the interests of the people of the state are

508 best served by such action; and

509 (b) the insurer:

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

511 (ii) intends to:

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

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

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

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

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

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

518 (7) An insurer that withdraws from writing all lines of insurance in this state may not

519 resume writing insurance in this state for five years unless~~[(a)]~~ the commissioner finds that

520 the prohibition should be waived because the waiver is:

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

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

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

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

525 Section 7. Section 31A-8-402.3 is amended to read:

526 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
527 **plans.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

549 (c) the plan sponsor:

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

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

553 (d) the insurer:

554 (i) elects to discontinue offering a particular health benefit product delivered or issued

555 for delivery in this state; and

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

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

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

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

560 (I) to the commissioner; and

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

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

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

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

565 or

566 (II) in the case of a large employer, any other health benefit product currently being

567 offered in that market; and

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

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

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

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

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

573 may become eligible for the coverage; or

574 (e) the insurer:

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

576 (A) the small employer market;

577 (B) the large employer market; or

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

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

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

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

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

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

584 to reside; and

585 (II) at least 30 working days prior to the date the notice is sent to the affected plan

586 sponsors, employees, and the dependents of the plan sponsors or employees;
587 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
588 market; and
589 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
590 (4) A large employer health benefit plan may be discontinued or nonrenewed:
591 (a) if a condition described in Subsection (2) exists; or
592 (b) for noncompliance with the insurer's:
593 (i) minimum participation requirements; or
594 (ii) employer contribution requirements.
595 (5) A small employer health benefit plan may be discontinued or nonrenewed:
596 (a) if a condition described in Subsection (2) exists; or
597 (b) for noncompliance with the insurer's employer contribution requirements.
598 (6) A small employer health benefit plan may be nonrenewed:
599 (a) if a condition described in Subsection (2) exists; or
600 (b) for noncompliance with the insurer's minimum participation requirements.
601 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
602 discontinued if after issuance of coverage the eligible employee:
603 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
604 or
605 (ii) makes an intentional misrepresentation of material fact in connection with the
606 coverage.
607 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
608 (i) 12 months after the date of discontinuance; and
609 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
610 to reenroll.
611 (c) At the time the eligible employee's coverage is discontinued under Subsection
612 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
613 discontinued.
614 (d) An eligible employee may not be discontinued under this Subsection (7) because of
615 a fraud or misrepresentation that relates to health status.
616 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to

617 the employer:

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

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

620 only through:

621 (i) an association;

622 (ii) a trust; or

623 (iii) a discretionary group.

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

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

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

627 Section 8. Section 31A-22-721 is amended to read:

628 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**

629 **nonrenewal.**

630 (1) Except as otherwise provided in this section, a health benefit plan for a plan

631 sponsor is renewable and continues in force:

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

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

634 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed~~[(a)]~~

635 for a network plan, if:

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

637 or works in:

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

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

640 ~~[(ii) in the case of the small employer market, the insurer applies the same criteria the~~

641 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7), or]~~

642 (b) for coverage made available in the small or large employer market only through an

643 association, if:

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

645 (ii) the coverage is terminated uniformly without regard to any health status-related

646 factor relating to any covered individual.

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

- 648 (a) a condition described in Subsection (2) exists;
- 649 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
650 terms of the contract;
- 651 (c) the plan sponsor:
 - 652 (i) performs an act or practice that constitutes fraud; or
 - 653 (ii) makes an intentional misrepresentation of material fact under the terms of the
654 coverage;
- 655 (d) the insurer:
 - 656 (i) elects to discontinue offering a particular health benefit product delivered or issued
657 for delivery in this state;
 - 658 (ii) (A) provides notice of the discontinuation in writing:
 - 659 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
 - 660 (II) at least 90 days before the date the coverage will be discontinued;
 - 661 (B) provides notice of the discontinuation in writing:
 - 662 (I) to the commissioner; and
 - 663 (II) at least three working days prior to the date the notice is sent to the affected plan
664 sponsors, employees, and dependents of plan sponsors or employees;
 - 665 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
666 other health benefit products currently being offered:
 - 667 (I) by the insurer in the market; or
 - 668 (II) in the case of a large employer, any other health benefit plan currently being
669 offered in that market; and
 - 670 (D) in exercising the option to discontinue that product and in offering the option of
671 coverage in this section, the insurer acts uniformly without regard to:
 - 672 (I) the claims experience of a plan sponsor;
 - 673 (II) any health status-related factor relating to any covered participant or beneficiary; or
 - 674 (III) any health status-related factor relating to a new participant or beneficiary who
675 may become eligible for coverage; or
 - 676 (e) the insurer:
 - 677 (i) elects to discontinue all of the insurer's health benefit plans:
 - 678 (A) in the small employer market; or

- 679 (B) the large employer market; or
680 (C) both the small and large employer markets; and
681 (ii) (A) provides notice of the discontinuance in writing:
682 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
683 (II) at least 180 days before the date the coverage will be discontinued;
684 (B) provides notice of the discontinuation in writing:
685 (I) to the commissioner in each state in which an affected insured individual is known
686 to reside; and
687 (II) at least 30 business days prior to the date the notice is sent to the affected plan
688 sponsors, employees, and dependents of a plan sponsor or employee;
689 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
690 market; and
691 (D) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).
692 (4) A large employer health benefit plan may be discontinued or nonrenewed:
693 (a) if a condition described in Subsection (2) exists; or
694 (b) for noncompliance with the insurer's:
695 (i) minimum participation requirements; or
696 (ii) employer contribution requirements.
697 (5) A small employer health benefit plan may be discontinued or nonrenewed:
698 (a) if a condition described in Subsection (2) exists; or
699 (b) for noncompliance with the insurer's employer contribution requirements.
700 (6) A small employer health benefit plan may be nonrenewed:
701 (a) if a condition described in Subsection (2) exists; or
702 (b) for noncompliance with the insurer's minimum participation requirements.
703 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
704 discontinued if after issuance of coverage the eligible employee:
705 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
706 or
707 (ii) makes an intentional misrepresentation of material fact in connection with the
708 coverage.
709 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:

710 (i) 12 months after the date of discontinuance; and
711 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
712 to reenroll.

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

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

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

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

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

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

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

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

732 (11) 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 (12) (a) A small employer that, after purchasing a health benefit plan in the small group

741 market, employs on average more than 50 eligible employees on each business day in a
742 calendar year may continue to renew the health benefit plan purchased in the small group
743 market.

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

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

749 Section 9. Section **31A-23b-202.5** is enacted to read:

750 **31A-23b-202.5. License types.**

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

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

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

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

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

765 Section 10. Section **31A-23b-205** is amended to read:

766 **31A-23b-205. Examination and training requirements.**

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

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

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

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

772 (c) other requirements that may be established by the commissioner by administrative
773 rule.

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

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

778 (a) accident and health insurance plans;

779 (b) qualifications for and enrollment in public programs;

780 (c) qualifications for and enrollment in premium subsidies;

781 (d) cultural and linguistic competence;

782 (e) conflict of interest standards;

783 (f) exchange functions; and

784 (g) other requirements that may be adopted by the commissioner by administrative
785 rule.

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

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

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

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

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

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

800 ~~[(5)] (6)~~ This section applies only to ~~[applicants who are natural persons]~~ an applicant
801 who is a natural person.

802 Section 11. Section **31A-23b-206** is amended to read:

803 **31A-23b-206. Continuing education requirements.**

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

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

808 (b) The commissioner may state a continuing education requirement in terms of hours
809 of instruction received in:

810 (i) accident and health insurance;

811 (ii) qualification for and enrollment in public programs;

812 (iii) qualification for and enrollment in premium subsidies;

813 (iv) cultural competency;

814 (v) conflict of interest standards; and

815 (vi) other exchange functions.

816 (3) (a) ~~Continuing~~ For a navigator line of authority, continuing education
817 requirements shall require:

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

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

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

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

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

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

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

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

834 ethics courses;

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

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

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

- 842 (i) classroom attendance;
- 843 (ii) home study;
- 844 (iii) watching a video recording; or
- 845 ~~[(iv) experience credit; or]~~
- 846 ~~[(v)]~~ (iv) another method approved by rule.

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

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

- 854 ~~[(A)]~~ (i) offer a qualified program on a geographically accessible basis; and
- 855 ~~[(B)]~~ (ii) collect a reasonable fee for funding and administration of a continuing
856 education program, subject to the review and approval of the commissioner.

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

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

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

863 (7) A navigator shall keep documentation of completing the continuing education
864 requirements of this section for two years after the end of the two-year licensing period to

865 which the continuing education applies.

866 Section 12. Section **31A-23b-211** is amended to read:

867 **31A-23b-211. Exceptions to navigator licensing.**

868 (1) For purposes of this section:

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

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

871 (c) "Solicit" is as defined in Section [31A-23a-102](#).

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

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

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

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

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

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

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

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

890 (ii) whose activities:

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

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

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

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

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

900 (e) a person who does not sell, solicit, or negotiate insurance and is not directly or
901 indirectly compensated by an insurer issuing an insurance contract, an agency administering a
902 public program, an individual who enrolled in a public program or insurance product, or an
903 exchange, including:

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

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

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

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

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

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

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

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

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

924 (i) special competence;

925 (ii) special trustworthiness; or

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

927 (b) other existing safeguards make regulation unnecessary.

928 Section 13. Section **31A-29-106** is amended to read:

929 **31A-29-106. Powers of board.**

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

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

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

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

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

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

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

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

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

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

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

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

955 [~~(h) coordinate with the Department of Health in seeking to obtain from the Centers for~~
956 ~~Medicare and Medicaid Services, or other appropriate office or agency of government, all~~
957 ~~appropriate waivers, authority, and permission needed to coordinate the coverage available~~

958 ~~from the pool with coverage available under Medicaid, either before or after Medicaid~~
959 ~~coverage, or as a conversion option upon completion of Medicaid eligibility, without the~~
960 ~~necessity for requalification by the enrollee;]~~

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

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

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

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

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

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

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

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

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

- 981 (i) the net premiums anticipated;
982 (ii) actuarial projections of payments required of the pool;
983 (iii) the expenses of administration; and
984 (iv) the anticipated reserves or losses of the pool.

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

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

989 ~~[(3)(a) The board shall on or before September 1, 2004, require the plan administrator~~
 990 ~~or an independent actuarial consultant retained by the plan administrator to redetermine the~~
 991 ~~reasonable equivalent of the criteria for uninsurability required under Subsection~~
 992 ~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.]~~

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

995 Section 14. Section **31A-29-110** is amended to read:

996 **31A-29-110. Pool administrator -- Selection -- Powers.**

997 (1) The board shall select a pool administrator in accordance with Title 63G, Chapter
 998 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the
 999 board, which shall include:

- 1000 (a) ability to manage medical expenses;
 1001 (b) proven ability to handle accident and health insurance;
 1002 (c) efficiency of claim paying procedures;
 1003 (d) marketing and underwriting;
 1004 (e) proven ability for managed care and quality assurance;
 1005 (f) provider contracting and discounts;
 1006 (g) pharmacy benefit management;
 1007 (h) an estimate of total charges for administering the pool; and
 1008 (i) ability to administer the pool in a cost-efficient manner.

1009 (2) A pool administrator may be:

- 1010 (a) a health insurer;
 1011 (b) a health maintenance organization;
 1012 (c) a third-party administrator; or
 1013 (d) any person or entity which has demonstrated ability to meet the criteria in
 1014 Subsection (1).

1015 (3) ~~[(a)]~~ The pool administrator shall serve for a period of three years, with ~~[two~~
 1016 ~~one-year]~~ yearly extension options until the operations of the pool are closed pursuant to
 1017 Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract
 1018 between the board and the administrator.

1019 ~~[(b) At least one year prior to the expiration of the contract between the board and the~~

1020 ~~pool administrator, the board shall invite all interested parties, including the current pool~~
1021 ~~administrator, to submit bids to serve as the pool administrator].~~

1022 ~~[(c) Selection of the pool administrator for a succeeding period shall be made at least~~
1023 ~~six months prior to the expiration of the period of service under Subsection (3)(a).]~~

1024 (4) The pool administrator is responsible for all operational functions of the pool and
1025 shall:

1026 (a) have access to all nonpatient specific experience data, statistics, treatment criteria,
1027 and guidelines compiled or adopted by the Medicaid program, the Public Employees Health
1028 Plan, the Department of Health, or the Insurance Department, and which are not otherwise
1029 declared by statute to be confidential;

1030 (b) perform all marketing, eligibility, enrollment, member agreements, and
1031 administrative claim payment functions relating to the pool;

1032 (c) establish, administer, and operate a monthly premium billing procedure for
1033 collection of premiums from enrollees;

1034 (d) perform all necessary functions to assure timely payment of benefits to enrollees,
1035 including:

1036 (i) making information available relating to the proper manner of submitting a claim
1037 for benefits to the pool administrator and distributing forms upon which submission shall be
1038 made; and

1039 (ii) evaluating the eligibility of each claim for payment by the pool;

1040 (e) submit regular reports to the board regarding the operation of the pool, the
1041 frequency, content, and form of which reports shall be determined by the board;

1042 (f) following the close of each calendar year, determine net written and earned
1043 premiums, the expense of administration, and the paid and incurred losses for the year and
1044 submit a report of this information to the board, the commissioner, and the Division of Finance
1045 on a form prescribed by the commissioner; and

1046 (g) be paid as provided in the plan of operation for expenses incurred in the
1047 performance of the pool administrator's services.

1048 Section 15. Section **31A-29-111** is amended to read:

1049 **31A-29-111. Eligibility -- Limitations.**

1050 (1) (a) Except as provided in Subsection (1)(b) and Subsection [31A-29-106\(1\)\(d\)](#), an

1051 individual who is not HIPAA eligible is eligible for pool coverage if the individual:

1052 (i) pays the established premium;

1053 (ii) is a resident of this state; and

1054 (iii) meets the health underwriting criteria under Subsection (5)(a).

1055 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not

1056 eligible for pool coverage if one or more of the following conditions apply:

1057 (i) the individual is eligible for health care benefits under Medicaid or Medicare,

1058 except as provided in Section [31A-29-112](#);

1059 (ii) the individual has terminated coverage in the pool, unless:

1060 (A) 12 months have elapsed since the termination date; or

1061 (B) the individual demonstrates that creditable coverage has been involuntarily

1062 terminated for any reason other than nonpayment of premium;

1063 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

1064 (iv) the individual is an inmate of a public institution;

1065 (v) the individual is eligible for a public health plan, as defined in federal regulations

1066 adopted pursuant to 42 U.S.C. 300gg;

1067 (vi) the individual's health condition does not meet the criteria established under

1068 Subsection (5);

1069 (vii) the individual is eligible for coverage under an employer group that offers a health

1070 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members

1071 as:

1072 (A) an eligible employee;

1073 (B) a dependent of an eligible employee; or

1074 (C) a member;

1075 (viii) the individual is covered under any other health benefit plan;

1076 (ix) except as provided in Subsections (3) and (6), at the time of application, the

1077 individual has not resided in Utah for at least 12 consecutive months preceding the date of

1078 application; or

1079 (x) the individual's employer pays any part of the individual's health benefit plan

1080 premium, either as an insured or a dependent, for pool coverage.

1081 (2) (a) Except as provided in Subsection (2)(b) and [Subsection 31A-29-106\(1\)\(d\)](#), an

1082 individual who is HIPAA eligible is eligible for pool coverage if the individual:

1083 (i) pays the established premium; and

1084 (ii) is a resident of this state.

1085 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for
1086 pool coverage if one or more of the following conditions apply:

1087 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
1088 except as provided in Section 31A-29-112;

1089 (ii) the individual is eligible for a public health plan, as defined in federal regulations
1090 adopted pursuant to 42 U.S.C. 300gg;

1091 (iii) the individual is covered under any other health benefit plan;

1092 (iv) the individual is eligible for coverage under an employer group that offers a health
1093 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members
1094 as:

1095 (A) an eligible employee;

1096 (B) a dependent of an eligible employee; or

1097 (C) a member;

1098 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

1099 (vi) the individual is an inmate of a public institution; or

1100 (vii) the individual's employer pays any part of the individual's health benefit plan
1101 premium, either as an insured or a dependent, for pool coverage.

1102 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
1103 (1)(a), an individual whose health care insurance coverage from a state high risk pool with
1104 similar coverage is terminated because of nonresidency in another state is eligible for coverage
1105 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

1106 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the
1107 termination date of the previous high risk pool coverage.

1108 (c) The effective date of this state's pool coverage shall be the date of termination of
1109 the previous high risk pool coverage.

1110 (d) The waiting period of an individual with a preexisting condition applying for
1111 coverage under this chapter shall be waived:

1112 (i) to the extent to which the waiting period was satisfied under a similar plan from

1113 another state; and

1114 (ii) if the other state's benefit limitation was not reached.

1115 (4) (a) If an eligible individual applies for pool coverage within 30 days of being
1116 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
1117 than the first day of the month following the date of submission of the completed insurance
1118 application to the carrier.

1119 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
1120 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
1121 coverage.

1122 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
1123 based on:

1124 (i) health condition; and

1125 (ii) expected claims so that the expected claims are anticipated to remain within
1126 available funding.

1127 (b) The board, with approval of the commissioner, may contract with one or more
1128 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting
1129 criteria under Subsection (5)(a).

1130 (c) If an individual is denied coverage by the pool under the criteria established in
1131 Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage
1132 under ~~[Subsection]~~ Section 31A-30-108~~(3)~~.

1133 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
1134 (1)(a), an individual whose individual health care insurance coverage was involuntarily
1135 terminated, is eligible for coverage under the pool subject to the conditions of Subsections
1136 (1)(b)(i) through (viii) and (x).

1137 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the
1138 termination date of the previous individual health care insurance coverage.

1139 (c) The effective date of this state's pool coverage shall be the date of termination of
1140 the previous individual coverage.

1141 (d) The waiting period of an individual with a preexisting condition applying for
1142 coverage under this chapter shall be waived to the extent to which the waiting period was
1143 satisfied under the individual health insurance plan.

1144 Section 16. Section 31A-29-113 is amended to read:

1145 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**
1146 **conditions -- Waiver -- Maximum benefits.**

1147 (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished
1148 for the diagnoses or treatment of illness or injury that:

1149 (i) exceed the deductible and copayment amounts applicable under Section
1150 31A-29-114; and

1151 (ii) are not otherwise limited or excluded.

1152 (b) Eligible medical expenses are the allowed charges established by the board for the
1153 health care services and items rendered during times for which benefits are extended under the
1154 pool policy.

1155 (c) Section 31A-21-313 applies to coverage issued under this chapter.

1156 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and
1157 other limitations shall be established by the board.

1158 (3) The commissioner shall approve the benefit package developed by the board to
1159 ensure its compliance with this chapter.

1160 [~~4~~] The pool shall offer at least one benefit plan through a managed care program as
1161 authorized under Section 31A-29-106.]

1162 [~~5~~] (4) This chapter may not be construed to prohibit the pool from issuing additional
1163 types of pool policies with different types of benefits which in the opinion of the board may be
1164 of benefit to the citizens of Utah.

1165 [~~6~~] (5) (a) The board shall design and require an administrator to employ cost
1166 containment measures and requirements including preadmission certification and concurrent
1167 inpatient review for the purpose of making the pool more cost effective.

1168 (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this
1169 chapter.

1170 [~~7~~] (6) (a) A pool policy may contain provisions under which coverage for a
1171 preexisting condition is excluded if:

1172 (i) the exclusion relates to a condition, regardless of the cause of the condition, for
1173 which medical advice, diagnosis, care, or treatment was recommended or received, from an
1174 individual licensed or similarly authorized to provide such services under state law and

1175 operating within the scope of practice authorized by state law, within the six-month period
 1176 ending on the effective date of plan coverage; and

1177 (ii) except as provided in Subsection (8), the exclusion extends for a period no longer
 1178 than the six-month period following the effective date of plan coverage for a given individual.

1179 (b) Subsection ~~[(7)]~~ (6)(a) does not apply to a HIPAA eligible individual.

1180 ~~[(8)]~~ (7) (a) A pool policy may contain provisions under which coverage for a
 1181 preexisting pregnancy is excluded during a ten-month period following the effective date of
 1182 plan coverage for a given individual.

1183 (b) Subsection ~~[(8)]~~ (7)(a) does not apply to a HIPAA eligible individual.

1184 ~~[(9)]~~ (8) (a) The pool will waive the preexisting condition exclusion described in
 1185 Subsections ~~[(7)]~~ (6)(a) and ~~[(8)]~~ (7)(a) for an individual that is changing health coverage to the
 1186 pool, to the extent to which similar exclusions have been satisfied under any prior health
 1187 insurance coverage if the individual applies not later than 63 days following the date of
 1188 involuntary termination, other than for nonpayment of premiums, from health coverage.

1189 (b) If this Subsection ~~[(9)]~~ (8) applies, coverage in the pool shall be effective from the
 1190 date on which the prior coverage was terminated.

1191 ~~[(10)]~~ (9) Covered benefits available from the pool may not exceed a \$1,800,000
 1192 lifetime maximum, which includes a per enrollee calendar year maximum established by the
 1193 board.

1194 Section 17. Section **31A-29-114** is amended to read:

1195 **31A-29-114. Deductibles -- Copayments.**

1196 (1) (a) A pool policy shall impose a deductible on a per calendar year basis.

1197 (b) At least two deductible plans shall be offered.

1198 (c) The deductible is applied to all of the eligible medical expenses ~~[as defined in~~
 1199 ~~Section 31A-29-113;~~] incurred by the enrollee until the deductible has been satisfied. There
 1200 are no benefits payable before the deductible has been satisfied.

1201 (d) The pool may offer separate deductibles for prescription benefits.

1202 (2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least
 1203 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess
 1204 of the mandatory deductible.

1205 (b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool

1206 policy.

1207 (3) The board shall establish maximum aggregate out-of-pocket payments for eligible
1208 medical expenses incurred by the enrollee for each of the deductible plans offered under
1209 Subsection (1)(b).

1210 (4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments
1211 under Subsection (3), the board may establish a coinsurance requirement to be imposed on
1212 eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

1213 (b) The circumstances in which the coinsurance authorized by this Subsection (4) may
1214 be imposed shall be designated in the pool policy.

1215 (c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to
1216 exceed 5% of eligible medical expenses.

1217 (5) The limits on maximum aggregate out-of-pocket payments for eligible medical
1218 expenses incurred by the enrollee under this section may not include out-of-pocket payments
1219 for prescription benefits.

1220 Section 18. Section **31A-29-115** is amended to read:

1221 **31A-29-115. Cancellation -- Notice.**

1222 (1) ~~[(a)]~~ On the date of renewal, the pool may cancel an enrollee's policy if:

1223 ~~[(i)]~~ (a) the enrollee's health condition does not meet the criteria established in
1224 Subsection **31A-29-111(5)**; and

1225 ~~[(ii)]~~ (b) the pool has provided written notice to the enrollee's last-known address no
1226 less than 60 days before cancellation~~;~~ and].

1227 ~~[(iii) at least one individual carrier has not reached the individual enrollment cap
1228 established in Section **31A-30-110**.]~~

1229 ~~[(b) The pool shall issue a certificate of insurability to an enrollee whose policy is
1230 cancelled under Subsection (1)(a) for coverage under Subsection **31A-30-108(3)** if the
1231 requirements of Subsection **31A-29-111(5)** are met.]~~

1232 (2) The pool may cancel an enrollee's policy at any time if:

1233 (a) the pool has provided written notice to the enrollee's last-known address no less
1234 than 15 days before cancellation; and

1235 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
1236 months;

1237 (ii) there is nonpayment of premiums; or
1238 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
1239 forth in Section 31A-29-111, in which case:

1240 (A) the policy may be retroactively terminated for the period of time in which the
1241 enrollee was not eligible;

1242 (B) retroactive termination may not exceed three years; and

1243 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
1244 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection
1245 31A-29-119(3).

1246 Section 19. Section 31A-30-103 is amended to read:

1247 **31A-30-103. Definitions.**

1248 As used in this chapter:

1249 (1) "Actuarial certification" means a written statement by a member of the American
1250 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
1251 is in compliance with Sections 31A-30-106 and 31A-30-106.1, based upon the examination of
1252 the covered carrier, including review of the appropriate records and of the actuarial
1253 assumptions and methods used by the covered carrier in establishing premium rates for
1254 applicable health benefit plans.

1255 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
1256 through one or more intermediaries, controls or is controlled by, or is under common control
1257 with, a specified entity or person.

1258 (3) "Base premium rate" means, for each class of business as to a rating period, the
1259 lowest premium rate charged or that could have been charged under a rating system for that
1260 class of business by the covered carrier to covered insureds with similar case characteristics for
1261 health benefit plans with the same or similar coverage.

1262 (4) (a) "Bona fide employer association" means an association of employers:

1263 (i) that meets the requirements of Subsection 31A-22-701(2)(b);

1264 (ii) in which the employers of the association, either directly or indirectly, exercise
1265 control over the plan;

1266 (iii) that is organized:

1267 (A) based on a commonality of interest between the employers and their employees

1268 that participate in the plan by some common economic or representation interest or genuine
1269 organizational relationship unrelated to the provision of benefits; and

1270 (B) to act in the best interests of its employers to provide benefits for the employer's
1271 employees and their spouses and dependents, and other benefits relating to employment; and

1272 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

1273 (b) The commissioner shall consider the following with regard to determining whether
1274 an association of employers is a bona fide employer association under Subsection (4)(a):

1275 (i) how association members are solicited;

1276 (ii) who participates in the association;

1277 (iii) the process by which the association was formed;

1278 (iv) the purposes for which the association was formed, and what, if any, were the
1279 pre-existing relationships of its members;

1280 (v) the powers, rights and privileges of employer members; and

1281 (vi) who actually controls and directs the activities and operations of the benefit
1282 programs.

1283 (5) "Carrier" means any person or entity that provides health insurance in this state
1284 including:

1285 (a) an insurance company;

1286 (b) a prepaid hospital or medical care plan;

1287 (c) a health maintenance organization;

1288 (d) a multiple employer welfare arrangement; and

1289 (e) any other person or entity providing a health insurance plan under this title.

1290 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
1291 demographic or other objective characteristics of a covered insured that are considered by the
1292 carrier in determining premium rates for the covered insured.

1293 (b) "Case characteristics" do not include:

1294 (i) duration of coverage since the policy was issued;

1295 (ii) claim experience; and

1296 (iii) health status.

1297 (7) "Class of business" means all or a separate grouping of covered insureds that is
1298 permitted by the commissioner in accordance with Section [31A-30-105](#).

- 1299 (8) "Conversion policy" means a policy providing coverage under the conversion
1300 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.
- 1301 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
1302 this chapter.
- 1303 (10) "Covered individual" means any individual who is covered under a health benefit
1304 plan subject to this chapter.
- 1305 (11) "Covered insureds" means small employers and individuals who are issued a
1306 health benefit plan that is subject to this chapter.
- 1307 (12) "Dependent" means an individual to the extent that the individual is defined to be
1308 a dependent by:
- 1309 (a) the health benefit plan covering the covered individual; and
1310 (b) Chapter 22, Part 6, Accident and Health Insurance.
- 1311 (13) "Established geographic service area" means a geographical area approved by the
1312 commissioner within which the carrier is authorized to provide coverage.
- 1313 (14) "Index rate" means, for each class of business as to a rating period for covered
1314 insureds with similar case characteristics, the arithmetic average of the applicable base
1315 premium rate and the corresponding highest premium rate.
- 1316 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
1317 through a health benefit plan regardless of whether:
- 1318 (a) coverage is offered through:
- 1319 (i) an association;
1320 (ii) a trust;
1321 (iii) a discretionary group; or
1322 (iv) other similar groups; or
- 1323 (b) the policy or contract is situated out-of-state.
- 1324 (16) "Individual conversion policy" means a conversion policy issued to:
- 1325 (a) an individual; or
1326 (b) an individual with a family.
- 1327 (17) "Individual coverage count" means the number of natural persons covered under a
1328 carrier's health benefit products that are individual policies.
- 1329 (18) "Individual enrollment cap" means the percentage set by the commissioner in

1330 accordance with Section 31A-30-110.

1331 (19) "New business premium rate" means, for each class of business as to a rating
1332 period, the lowest premium rate charged or offered, or that could have been charged or offered,
1333 by the carrier to covered insureds with similar case characteristics for newly issued health
1334 benefit plans with the same or similar coverage.

1335 (20) "Premium" means money paid by covered insureds and covered individuals as a
1336 condition of receiving coverage from a covered carrier, including any fees or other
1337 contributions associated with the health benefit plan.

1338 (21) (a) "Rating period" means the calendar period for which premium rates
1339 established by a covered carrier are assumed to be in effect, as determined by the carrier.

1340 (b) A covered carrier may not have:

1341 (i) more than one rating period in any calendar month; and

1342 (ii) no more than 12 rating periods in any calendar year.

1343 (22) "Resident" means an individual who has resided in this state for at least 12
1344 consecutive months immediately preceding the date of application.

1345 (23) "Short-term limited duration insurance" means a health benefit product that:

1346 (a) is not renewable; and

1347 (b) has an expiration date specified in the contract that is less than 364 days after the
1348 date the plan became effective.

1349 (24) "Small employer carrier" means a carrier that provides health benefit plans
1350 covering eligible employees of one or more small employers in this state, regardless of
1351 whether:

1352 (a) coverage is offered through:

1353 (i) an association;

1354 (ii) a trust;

1355 (iii) a discretionary group; or

1356 (iv) other similar grouping; or

1357 (b) the policy or contract is situated out-of-state.

1358 [~~(25) "Uninsurable" means an individual who:~~]

1359 [~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the~~
1360 ~~underwriting criteria established in Subsection 31A-29-111(5); or]~~

1361 ~~[(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and]~~
 1362 ~~[(ii) has a condition of health that does not meet consistently applied underwriting]~~
 1363 ~~criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g)~~
 1364 ~~and (h) for which coverage the applicant is applying.]~~

1365 ~~[(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for]~~
 1366 ~~purposes of this formula:]~~

1367 ~~[(a) "CI" means the carrier's individual coverage count as of December 31 of the]~~
 1368 ~~preceding year; and]~~

1369 ~~[(b) "UC" means the number of uninsurable individuals who were issued an individual]~~
 1370 ~~policy on or after July 1, 1997.]~~

1371 Section 20. Section 31A-30-107 is amended to read:

1372 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
 1373 **nonrenewal.**

1374 (1) Except as otherwise provided in this section, a small employer health benefit plan is
 1375 renewable and continues in force:

1376 (a) with respect to all eligible employees and dependents; and

1377 (b) at the option of the plan sponsor.

1378 (2) A small employer health benefit plan may be discontinued or nonrenewed:

1379 (a) for a network plan, if ~~[(t)]~~ there is no longer any enrollee under the group health
 1380 plan who lives, resides, or works in:

1381 ~~[(A)]~~ (i) the service area of the covered carrier; or

1382 ~~[(B)]~~ (ii) the area for which the covered carrier is authorized to do business; ~~[and]~~ or

1383 ~~[(ii) in the case of the small employer market, the small employer carrier applies the]~~
 1384 ~~same criteria the small employer carrier would apply in denying enrollment in the plan under]~~
 1385 ~~Subsection 31A-30-108(7); or]~~

1386 (b) for coverage made available in the small or large employer market only through an
 1387 association, if:

1388 (i) the employer's membership in the association ceases; and

1389 (ii) the coverage is terminated uniformly without regard to any health status-related
 1390 factor relating to any covered individual.

1391 (3) A small employer health benefit plan may be discontinued if:

- 1392 (a) a condition described in Subsection (2) exists;
- 1393 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
- 1394 premiums or contributions in accordance with the terms of the contract;
- 1395 (c) the plan sponsor:
- 1396 (i) performs an act or practice that constitutes fraud; or
- 1397 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 1398 coverage;
- 1399 (d) the covered carrier:
- 1400 (i) elects to discontinue offering a particular small employer health benefit product
- 1401 delivered or issued for delivery in this state; and
- 1402 (ii) (A) provides notice of the discontinuation in writing:
- 1403 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 1404 (II) at least 90 days before the date the coverage will be discontinued;
- 1405 (B) provides notice of the discontinuation in writing:
- 1406 (I) to the commissioner; and
- 1407 (II) at least three working days prior to the date the notice is sent to the affected plan
- 1408 sponsors, employees, and dependents of the plan sponsors or employees;
- 1409 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
- 1410 other small employer health benefit products currently being offered by the small employer
- 1411 carrier in the market; and
- 1412 (D) in exercising the option to discontinue that product and in offering the option of
- 1413 coverage in this section, acts uniformly without regard to:
- 1414 (I) the claims experience of a plan sponsor;
- 1415 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 1416 (III) any health status-related factor relating to any new participant or beneficiary who
- 1417 may become eligible for the coverage; or
- 1418 (e) the covered carrier:
- 1419 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
- 1420 in:
- 1421 (A) the small employer market;
- 1422 (B) the large employer market; or

- 1423 (C) both the small employer and large employer markets; and
1424 (ii) (A) provides notice of the discontinuation in writing:
1425 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1426 (II) at least 180 days before the date the coverage will be discontinued;
1427 (B) provides notice of the discontinuation in writing:
1428 (I) to the commissioner in each state in which an affected insured individual is known
1429 to reside; and
1430 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1431 sponsors, employees, and the dependents of the plan sponsors or employees;
1432 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1433 market; and
1434 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
1435 (4) A small employer health benefit plan may be discontinued or nonrenewed:
1436 (a) if a condition described in Subsection (2) exists; or
1437 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1438 employer contribution requirements.
1439 (5) A small employer health benefit plan may be nonrenewed:
1440 (a) if a condition described in Subsection (2) exists; or
1441 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
1442 minimum participation requirements.
1443 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
1444 discontinued if after issuance of coverage the eligible employee:
1445 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
1446 or
1447 (ii) makes an intentional misrepresentation of material fact in connection with the
1448 coverage.
1449 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
1450 (i) 12 months after the date of discontinuance; and
1451 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1452 to reenroll.
1453 (c) At the time the eligible employee's coverage is discontinued under Subsection

1454 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
1455 coverage is discontinued.

1456 (d) An eligible employee may not be discontinued under this Subsection (6) because of
1457 a fraud or misrepresentation that relates to health status.

1458 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
1459 the employer:

1460 (a) with respect to coverage provided to an employer member of the association; and

1461 (b) if the small employer health benefit plan is made available by a covered carrier in
1462 the employer market only through:

1463 (i) an association;

1464 (ii) a trust; or

1465 (iii) a discretionary group.

1466 (8) A covered carrier may modify a small employer health benefit plan only:

1467 (a) at the time of coverage renewal; and

1468 (b) if the modification is effective uniformly among all plans with that product.

1469 Section 21. Section **31A-30-108** is amended to read:

1470 **31A-30-108. Eligibility for small employer and individual market.**

1471 (1) (a) [~~Small employer carriers shall accept residents~~] A small employer carrier shall
1472 accept a small employer that applies for small group coverage as set forth in the Health
1473 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a) and PPACA, Sec. 2702.

1474 [~~(b) Individual carriers shall accept residents for individual coverage pursuant to:~~]

1475 [~~(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and]~~

1476 [~~(ii) Subsection (3).]~~

1477 (b) An individual carrier shall accept an individual that applies for individual coverage
1478 as set forth in PPACA, Sec. 2702.

1479 (2) (a) [~~Small~~] A small employer [~~carriers~~] carrier shall offer to accept all eligible
1480 employees and their dependents at the same level of benefits under any health benefit plan
1481 provided to a small employer.

1482 (b) [~~Small~~] A small employer [~~carriers~~] carrier may:

1483 (i) request a small employer to submit a copy of the small employer's quarterly income
1484 tax withholdings to determine whether the employees for whom coverage is provided or

1485 requested are bona fide employees of the small employer; and

1486 (ii) deny or terminate coverage if the small employer refuses to provide documentation

1487 requested under Subsection (2)(b)(i).

1488 ~~[(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~

1489 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:]~~

1490 ~~[(a) the individual is not covered or eligible for coverage:]~~

1491 ~~[(i) (A) as an employee of an employer;~~

1492 ~~[(B) as a member of an association; or]~~

1493 ~~[(C) as a member of any other group; and]~~

1494 ~~[(ii) under:]~~

1495 ~~[(A) a health benefit plan; or]~~

1496 ~~[(B) a self-insured arrangement that provides coverage similar to that provided by a~~

1497 ~~health benefit plan as defined in Section 31A-1-301;]~~

1498 ~~[(b) the individual is not covered and is not eligible for coverage under any public~~

1499 ~~health benefits arrangement including:]~~

1500 ~~[(i) the Medicare program established under Title XVIII of the Social Security Act;]~~

1501 ~~[(ii) any act of Congress or law of this or any other state that provides benefits~~

1502 ~~comparable to the benefits provided under this chapter; or]~~

1503 ~~[(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter~~

1504 ~~29, Comprehensive Health Insurance Pool Act;]~~

1505 ~~[(c) unless the maximum benefit has been reached the individual is not covered or~~

1506 ~~eligible for coverage under any:]~~

1507 ~~[(i) Medicare supplement policy;]~~

1508 ~~[(ii) conversion option;]~~

1509 ~~[(iii) continuation or extension under COBRA; or]~~

1510 ~~[(iv) state extension;]~~

1511 ~~[(d) the individual has not terminated or declined coverage described in Subsection~~

1512 ~~(3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for~~

1513 ~~individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),~~

1514 ~~in which case, the requirement of this Subsection (3)(d) does not apply; and]~~

1515 ~~[(e) the individual is certified as ineligible for the Health Insurance Pool if:]~~

1516 ~~[(i) the individual applies for coverage with the Comprehensive Health Insurance Pool~~
1517 ~~within 30 days after being rejected or refused coverage by the covered carrier and reapplies for~~
1518 ~~coverage with that covered carrier within 30 days after the date of issuance of a certificate~~
1519 ~~under Subsection 31A-29-111(5)(c); or]~~

1520 ~~[(ii) the individual applies for coverage with any individual carrier within 45 days~~
1521 ~~after:]~~

1522 ~~[(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or]~~

1523 ~~[(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the~~
1524 ~~individual applied first for coverage with the Comprehensive Health Insurance Pool.]~~

1525 ~~[(4) (a) If coverage is obtained under Subsection (3)(c)(i) and the required premium is~~
1526 ~~paid, the effective date of coverage shall be the first day of the month following the individual's~~
1527 ~~submission of a completed insurance application to that covered carrier.]~~

1528 ~~[(b) If coverage is obtained under Subsection (3)(c)(ii) and the required premium is~~
1529 ~~paid, the effective date of coverage shall be the day following the:]~~

1530 ~~[(i) cancellation of coverage under Subsection 31A-29-115(1); or]~~

1531 ~~[(ii) submission of a completed insurance application to the Comprehensive Health~~
1532 ~~Insurance Pool].~~

1533 ~~[(5) (a) An individual carrier is not required to accept individuals for coverage under~~
1534 ~~Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]~~

1535 ~~[(b) A carrier described in Subsection (5)(a) may not issue new individual policies in~~
1536 ~~the state for five years from July 1, 1997.]~~

1537 ~~[(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new~~
1538 ~~policies after July 1, 1999, which may only be granted if:]~~

1539 ~~[(i) the carrier accepts uninsurables as is required of a carrier entering the market under~~
1540 ~~Subsection 31A-30-110; and]~~

1541 ~~[(ii) the commissioner finds that the carrier's issuance of new individual policies:]~~

1542 ~~[(A) is in the best interests of the state; and]~~

1543 ~~[(B) does not provide an unfair advantage to the carrier.]~~

1544 ~~[(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29;~~
1545 ~~Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is~~
1546 ~~capped or suspended, an individual carrier may decline to accept individuals applying for~~

1547 individual enrollment, other than individuals applying for coverage as set forth in Health
1548 Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]

1549 [~~(b) Within two calendar days of taking action under Subsection (6)(a), an individual~~
1550 ~~carrier will provide written notice to the department.]~~

1551 [~~(7) (a) If a small employer carrier offers health benefit plans to small employers~~
1552 ~~through a network plan, the small employer carrier may:]~~

1553 [~~(i) limit the employers that may apply for the coverage to those employers with~~
1554 ~~eligible employees who live, reside, or work in the service area for the network plan; and]~~

1555 [~~(ii) within the service area of the network plan, deny coverage to an employer if the~~
1556 ~~small employer carrier has demonstrated to the commissioner that the small employer carrier:]~~

1557 [~~(A) will not have the capacity to deliver services adequately to enrollees of any~~
1558 ~~additional groups because of the small employer carrier's obligations to existing group contract~~
1559 ~~holders and enrollees; and]~~

1560 [~~(B) applies this section uniformly to all employers without regard to:]~~

1561 [~~(F) the claims experience of an employer, an employer's employee, or a dependent of~~
1562 ~~an employee; or]~~

1563 [~~(H) any health status-related factor relating to an employee or dependent of an~~
1564 ~~employee].~~

1565 [~~(b) (i) A small employer carrier that denies a health benefit product to an employer in~~
1566 ~~any service area in accordance with this section may not offer coverage in the small employer~~
1567 ~~market within the service area to any employer for a period of 180 days after the date the~~
1568 ~~coverage is denied.]~~

1569 [~~(ii) This Subsection (7)(b) does not:]~~

1570 [~~(A) limit the small employer carrier's ability to renew coverage that is in force; or]~~

1571 [~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~
1572 ~~force.]~~

1573 [~~(c) Coverage offered within a service area after the 180-day period specified in~~
1574 ~~Subsection (7)(b) is subject to the requirements of this section.]~~

1575 Section 22. Section **31A-30-117** is amended to read:

1576 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**

1577 (1) (a) After complying with the reporting requirements of Section [63M-1-2505.5](#), the

1578 commissioner may adopt administrative rules that change the rating and underwriting
1579 requirements of this chapter as necessary to transition the insurance market to meet federal
1580 qualified health plan standards and rating practices under PPACA.

1581 (b) Administrative rules adopted by the commissioner under this section may include:

1582 (i) the regulation of health benefit plans as described in Subsections 31A-2-212(5)(a)
1583 and (b); and

1584 (ii) disclosure of records and information required by PPACA and state law.

1585 (c) (i) The commissioner shall establish by administrative rule one statewide open
1586 enrollment period that applies to the individual insurance market that is not on the PPACA
1587 certified individual exchange.

1588 (ii) The statewide open enrollment period:

1589 (A) may be shorter, but no longer than the open enrollment period established for the
1590 individual insurance market offered in the PPACA certified exchange; and

1591 (B) may not be extended beyond the dates of the open enrollment period established
1592 for the individual insurance market offered in the PPACA certified exchange.

1593 (2) A carrier that offers health benefit plans in the individual market that is not part of
1594 the individual PPACA certified exchange:

1595 (a) shall open enrollment:

1596 (i) during the statewide open enrollment period established in Subsection (1)(c); and

1597 (ii) at other times, for qualifying events, as determined by administrative rule adopted
1598 by the commissioner; and

1599 (b) may open enrollment at any time.

1600 [~~(3)(a) The commissioner shall identify a new mandated benefit that is in excess of the~~
1601 ~~essential health benefits required by PPACA.]~~

1602 [~~(b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to~~
1603 ~~defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c)~~
1604 ~~directly to the qualified health plan issuer on behalf of an individual who receives an advance~~
1605 ~~premium tax credit under PPACA.]~~

1606 [~~(c) The state shall quantify the cost attributable to each additional mandated benefit~~
1607 ~~specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost~~
1608 ~~associated with the mandated benefit, which shall be:]~~

1609 ~~[(i) calculated in accordance with generally accepted actuarial principles and~~
1610 ~~methodologies;]~~

1611 ~~[(ii) conducted by a member of the American Academy of Actuaries; and]~~

1612 ~~[(iii) reported to the commissioner and to the individual exchange operating in the~~
1613 ~~state.]~~

1614 ~~[(d) The commissioner may require a proponent of a new mandated benefit under~~
1615 ~~Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance~~
1616 ~~with Subsection (3)(c). The commissioner may use the cost information provided under this~~
1617 ~~Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under~~
1618 ~~Subsection (3)(b).]~~

1619 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,
1620 or federal regulation, the commissioner shall allow a health insurer to choose to continue
1621 coverage and individuals and small employers to choose to re-enroll in coverage in
1622 nongrandfathered health coverage that is not in compliance with market reforms required by
1623 PPACA.

1624 Section 23. Section **31A-30-118** is enacted to read:

1625 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**
1626 **mandates -- Cost of additional benefits.**

1627 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the
1628 essential health benefits required by PPACA.

1629 (b) The state shall quantify the cost attributable to each additional mandated benefit
1630 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost
1631 associated with the mandated benefit, which shall be:

1632 (i) calculated in accordance with generally accepted actuarial principles and
1633 methodologies;

1634 (ii) conducted by a member of the American Academy of Actuaries; and

1635 (iii) reported to the commissioner and to the individual exchange operating in the state.

1636 (c) The commissioner may require a proponent of a new mandated benefit under
1637 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance
1638 with Subsection (1)(b). The commissioner may use the cost information provided under this
1639 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

1640 (2) If the state is required to defray the cost of additional required benefits under the
1641 provisions of 45 C.F.R. 155.170:

1642 (a) the state shall make the required payments:

1643 (i) in accordance with Subsection (3); and

1644 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

1645 (b) an issuer of a qualified health plan that receives a payment under the provisions of
1646 Subsection (1) and 45 C.F.R. 155.170 shall:

1647 (i) reduce the premium charged to the individual on whose behalf the issuer will be
1648 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection
1649 (1); or

1650 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an
1651 individual on whose behalf the issuer received a payment under Subsection (1), in an amount
1652 equal to the amount of the payment under Subsection (1); and

1653 (c) a premium rebate made under this section is not a prohibited inducement under
1654 Section 31A-23a-402.5.

1655 (3) A payment required under 45 C.F.R. 155.170(c) shall:

1656 (a) unless otherwise required by PPACA, be based on a statewide average of the cost
1657 of the additional benefit for all issuers who are entitled to payment under the provisions of 45
1658 C.F.R. 155.70; and

1659 (b) be submitted to an issuer through a process established and administered by:

1660 (i) the federal marketplace exchange for the state under PPACA for individual health
1661 plans; or

1662 (ii) Avenue H small employer market exchange for qualified health plans offered on
1663 the exchange.

1664 (4) The commissioner:

1665 (a) may adopt rules as necessary to administer the provisions of this section and 45
1666 C.F.R. 155.170; and

1667 (b) may not establish or implement the process for submitting the payments to an issuer
1668 under Subsection (3)(b)(i) unless the cost of establishing and implementing the process for
1669 submitting payments is paid for by the federal exchange marketplace.

1670 Section 24. Section **31A-30-301** is enacted to read:

1671 **Part 3. Individual and Small Employer Risk Adjustment Act**1672 **31A-30-301. Title.**1673 This part is known as the "Individual and Small Employer Risk Adjustment Act."1674 Section 25. Section **31A-30-302** is enacted to read:1675 **31A-30-302. Creation of state risk adjustment program.**

1676 (1) The commissioner shall convene a group of stakeholders and actuaries to assist the
1677 commissioner with the evaluation or the risk adjustment options described in Subsection (2). If
1678 the commissioner determines that a state-based risk adjustment program is in the best interest
1679 of the state, the commissioner shall establish an individual and small employer market risk
1680 adjustment program in accordance with 42 U.S.C. 18063 and this section.

1681 (2) The risk adjustment program adopted by the commissioner may include one of the
1682 following models:

1683 (a) continue the United States Department of Health and Human Services
1684 administration of the federal model for risk adjustment for the individual and small employer
1685 market in the state;

1686 (b) have the state administer the federal model for risk adjustment for the individual
1687 and small employer market in the state;

1688 (c) establish and operate a state based risk adjustment program for the individual and
1689 small employer market in the state; or

1690 (d) another risk adjustment model developed by the commissioner under Subsection

1691 (1).

1692 (3) Before adopting one of the models described in Subsection (2), the commissioner:

1693 (a) may enter into contracts to carry out the services needed to evaluate and establish
1694 one of the risk adjustment options described in Subsection (2); and

1695 (b) shall, prior to October 30, 2014, comply with the reporting requirements of Section
1696 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options
1697 described in Subsection (2).

1698 (4) The commissioner may:

1699 (a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah
1700 Administrative Rulemaking Act, that require an insurer that is subject to the state based risk
1701 adjustment program to submit data to the all payers claims database created under Section

1702 [26-33a-106.1](#); and

1703 (b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act,
1704 to cover the ongoing administrative cost of running the state based risk adjustment program.

1705 Section 26. Section **31A-30-303** is enacted to read:

1706 **31A-30-303. Enterprise fund.**

1707 (1) There is created an enterprise fund known as the Individual and Small Employer
1708 Risk Adjustment Enterprise Fund.

1709 (2) The following funds shall be credited to the pool fund:

1710 (a) appropriations from the General Fund;

1711 (b) fees established by the commissioner under Section [31A-30-302](#);

1712 (c) risk adjustment payments received from insurers participating in the risk adjustment
1713 program; and

1714 (d) all interest and dividends earned on the fund's assets.

1715 (3) All money received by the fund shall be deposited in compliance with Section
1716 [51-4-1](#) and shall be held by the state treasurer and invested in accordance with Title 51,
1717 Chapter 7, State Money Management Act.

1718 (4) The fund shall comply with the accounting policies, procedures, and reporting
1719 requirements established by the Division of Finance.

1720 (5) The fund shall comply with Title 63A, Utah Administrative Services Code.

1721 (6) The fund shall be used to implement and operate the risk adjustment program
1722 created by this part.

1723 Section 27. Section **63A-5-205** is amended to read:

1724 **63A-5-205. Contracting powers of director -- Retainage -- Health insurance**
1725 **coverage.**

1726 (1) As used in this section:

1727 (a) "Capital developments" has the same meaning as provided in Section [63A-5-104](#).

1728 (b) "Capital improvements" has the same meaning as provided in Section [63A-5-104](#).

1729 (c) "Employee" means an "employee," "worker," or "operative" as defined in Section
1730 [34A-2-104](#) who:

1731 (i) works at least 30 hours per calendar week; and

1732 (ii) meets employer eligibility waiting requirements for health care insurance which

1733 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
1734 hire.

1735 (d) "Health benefit plan" has the same meaning as provided in Section [31A-1-301](#).

1736 (e) "Qualified health insurance coverage" is as defined in Section [26-40-115](#).

1737 (f) "Subcontractor" has the same meaning provided for in Section [63A-5-208](#).

1738 (2) In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the director
1739 may:

1740 (a) subject to Subsection (3), enter into contracts for any work or professional services
1741 which the division or the State Building Board may do or have done; and

1742 (b) as a condition of any contract for architectural or engineering services, prohibit the
1743 architect or engineer from retaining a sales or agent engineer for the necessary design work.

1744 (3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design
1745 or construction contracts entered into by the division or the State Building Board on or after
1746 July 1, 2009, and:

1747 (i) applies to a prime contractor if the prime contract is in the amount of \$1,500,000 or
1748 greater; and

1749 (ii) applies to a subcontractor if the subcontract is in the amount of \$750,000 or greater.

1750 (b) This Subsection (3) does not apply:

1751 (i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

1752 (ii) if the contract is a sole source contract;

1753 (iii) if the contract is an emergency procurement; or

1754 (iv) to a change order as defined in Section [63G-6a-103](#), or a modification to a
1755 contract, when the contract does not meet the threshold required by Subsection (3)(a).

1756 (c) A person who intentionally uses change orders or contract modifications to
1757 circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

1758 (d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that
1759 the contractor has and will maintain an offer of qualified health insurance coverage for the
1760 contractor's employees and the employees' dependents.

1761 (ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor
1762 shall demonstrate to the director that the subcontractor has and will maintain an offer of
1763 qualified health insurance coverage for the subcontractor's employees and the employees'

1764 dependents.

1765 (e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)
1766 during the duration of the contract is subject to penalties in accordance with administrative
1767 rules adopted by the division under Subsection (3)(f).

1768 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1769 requirements of Subsection (3)(d)(ii).

1770 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)
1771 during the duration of the contract is subject to penalties in accordance with administrative
1772 rules adopted by the division under Subsection (3)(f).

1773 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1774 requirements of Subsection (3)(d)(i).

1775 (f) The division shall adopt administrative rules:

1776 (i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

1777 (ii) in coordination with:

1778 (A) the Department of Environmental Quality in accordance with Section 19-1-206;

1779 (B) the Department of Natural Resources in accordance with Section 79-2-404;

1780 (C) a public transit district in accordance with Section 17B-2a-818.5;

1781 (D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

1782 (E) the Department of Transportation in accordance with Section 72-6-107.5; and

1783 (F) the Legislature's Administrative Rules Review Committee; and

1784 (iii) which establish:

1785 (A) the requirements and procedures a contractor must follow to demonstrate to the
1786 director compliance with this Subsection (3) which shall include:

1787 (I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i)
1788 or (ii) more than twice in any 12-month period; and

1789 (II) that the actuarially equivalent determination required for the qualified health
1790 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
1791 department or division with a written statement of actuarial equivalency from either:

1792 (Aa) the Utah Insurance Department;

1793 (Bb) an actuary selected by the contractor or the contractor's insurer; or

1794 (Cc) an underwriter who is responsible for developing the employer group's premium

1795 rates;

1796 (B) the penalties that may be imposed if a contractor or subcontractor intentionally
1797 violates the provisions of this Subsection (3), which may include:

1798 (I) a three-month suspension of the contractor or subcontractor from entering into
1799 future contracts with the state upon the first violation;

1800 (II) a six-month suspension of the contractor or subcontractor from entering into future
1801 contracts with the state upon the second violation;

1802 (III) an action for debarment of the contractor or subcontractor in accordance with
1803 Section [63G-6a-904](#) upon the third or subsequent violation; and

1804 (IV) monetary penalties which may not exceed 50% of the amount necessary to
1805 purchase qualified health insurance coverage for an employee and the dependents of an
1806 employee of the contractor or subcontractor who was not offered qualified health insurance
1807 coverage during the duration of the contract; and

1808 (C) a website on which the department shall post the benchmark for the qualified
1809 health insurance coverage identified in Subsection (1)(e).

1810 (g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or
1811 subcontractor who intentionally violates the provisions of this section shall be liable to the
1812 employee for health care costs that would have been covered by qualified health insurance
1813 coverage.

1814 (ii) An employer has an affirmative defense to a cause of action under Subsection
1815 (3)(g)(i) if:

1816 (A) the employer relied in good faith on a written statement of actuarial equivalency
1817 provided by:

1818 (I) an actuary; or

1819 (II) an underwriter who is responsible for developing the employer group's premium
1820 rates; or

1821 (B) the department determines that compliance with this section is not required under
1822 the provisions of Subsection (3)(b).

1823 (iii) An employee has a private right of action only against the employee's employer to
1824 enforce the provisions of this Subsection (3)(g).

1825 (h) Any penalties imposed and collected under this section shall be deposited into the

1826 Medicaid Restricted Account created by Section 26-18-402.

1827 (i) The failure of a contractor or subcontractor to provide qualified health insurance
1828 coverage as required by this section:

1829 (i) may not be the basis for a protest or other action from a prospective bidder, offeror,
1830 or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah
1831 Procurement Code; and

1832 (ii) may not be used by the procurement entity or a prospective bidder, offeror, or
1833 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
1834 or construction.

1835 (4) The judgment of the director as to the responsibility and qualifications of a bidder
1836 is conclusive, except in case of fraud or bad faith.

1837 (5) The division shall make all payments to the contractor for completed work in
1838 accordance with the contract and pay the interest specified in the contract on any payments that
1839 are late.

1840 (6) If any payment on a contract with a private contractor to do work for the division or
1841 the State Building Board is retained or withheld, it shall be retained or withheld and released as
1842 provided in Section 13-8-5.

1843 Section 28. Section 63C-9-403 is amended to read:

1844 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

1845 (1) For purposes of this section:

1846 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
1847 34A-2-104 who:

1848 (i) works at least 30 hours per calendar week; and

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

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

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

1853 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

1854 (2) (a) Except as provided in Subsection (3), this section applies to a design or
1855 construction contract entered into by the board or on behalf of the board on or after July 1,
1856 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).

1857 (b) (i) A prime contractor is subject to this section if the prime contract is in the
1858 amount of \$1,500,000 or greater.

1859 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
1860 \$750,000 or greater.

1861 (3) This section does not apply if:

1862 (a) the application of this section jeopardizes the receipt of federal funds;

1863 (b) the contract is a sole source contract; or

1864 (c) the contract is an emergency procurement.

1865 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
1866 or a modification to a contract, when the contract does not meet the initial threshold required
1867 by Subsection (2).

1868 (b) A person who intentionally uses change orders or contract modifications to
1869 circumvent the requirements of Subsection (2) is guilty of an infraction.

1870 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
1871 director that the contractor has and will maintain an offer of qualified health insurance
1872 coverage for the contractor's employees and the employees' dependents during the duration of
1873 the contract.

1874 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor
1875 shall demonstrate to the executive director that the subcontractor has and will maintain an offer
1876 of qualified health insurance coverage for the subcontractor's employees and the employees'
1877 dependents during the duration of the contract.

1878 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
1879 the duration of the contract is subject to penalties in accordance with administrative rules
1880 adopted by the division under Subsection (6).

1881 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
1882 requirements of Subsection (5)(b).

1883 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
1884 the duration of the contract is subject to penalties in accordance with administrative rules
1885 adopted by the department under Subsection (6).

1886 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
1887 requirements of Subsection (5)(a).

- 1888 (6) The department shall adopt administrative rules:
- 1889 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
- 1890 (b) in coordination with:
- 1891 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
- 1892 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
- 1893 (iii) the State Building Board in accordance with Section 63A-5-205;
- 1894 (iv) a public transit district in accordance with Section 17B-2a-818.5;
- 1895 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
- 1896 (vi) the Legislature's Administrative Rules Review Committee; and
- 1897 (c) which establish:
- 1898 (i) the requirements and procedures a contractor must follow to demonstrate to the
- 1899 executive director compliance with this section which shall include:
- 1900 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
- 1901 (b) more than twice in any 12-month period; and
- 1902 (B) that the actuarially equivalent determination required for the qualified health
- 1903 insurance coverage in Subsection (1) is met by the contractor if the contractor provides the
- 1904 department or division with a written statement of actuarial equivalency from either:
- 1905 (I) the Utah Insurance Department;
- 1906 (II) an actuary selected by the contractor or the contractor's insurer; or
- 1907 (III) an underwriter who is responsible for developing the employer group's premium
- 1908 rates;
- 1909 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
- 1910 violates the provisions of this section, which may include:
- 1911 (A) a three-month suspension of the contractor or subcontractor from entering into
- 1912 future contracts with the state upon the first violation;
- 1913 (B) a six-month suspension of the contractor or subcontractor from entering into future
- 1914 contracts with the state upon the second violation;
- 1915 (C) an action for debarment of the contractor or subcontractor in accordance with
- 1916 Section 63G-6a-904 upon the third or subsequent violation; and
- 1917 (D) monetary penalties which may not exceed 50% of the amount necessary to
- 1918 purchase qualified health insurance coverage for employees and dependents of employees of

1919 the contractor or subcontractor who were not offered qualified health insurance coverage
1920 during the duration of the contract; and

1921 (iii) a website on which the department shall post the benchmark for the qualified
1922 health insurance coverage identified in Subsection (1)(c).

1923 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
1924 subcontractor who intentionally violates the provisions of this section shall be liable to the
1925 employee for health care costs that would have been covered by qualified health insurance
1926 coverage.

1927 (ii) An employer has an affirmative defense to a cause of action under Subsection
1928 (7)(a)(i) if:

1929 (A) the employer relied in good faith on a written statement of actuarial equivalency
1930 provided by:

1931 (I) an actuary; or

1932 (II) an underwriter who is responsible for developing the employer group's premium
1933 rates; or

1934 (B) the department determines that compliance with this section is not required under
1935 the provisions of Subsection (3) or (4).

1936 (b) An employee has a private right of action only against the employee's employer to
1937 enforce the provisions of this Subsection (7).

1938 (8) Any penalties imposed and collected under this section shall be deposited into the
1939 Medicaid Restricted Account created in Section [26-18-402](#).

1940 (9) The failure of a contractor or subcontractor to provide qualified health insurance
1941 coverage as required by this section:

1942 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
1943 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
1944 Procurement Code; and

1945 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
1946 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
1947 or construction.

1948 Section 29. Section **63I-1-231 (Effective 07/01/14)** is amended to read:

1949 **63I-1-231 (Effective 07/01/14). Repeal dates, Title 31A.**

- 1950 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.
- 1951 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2023.
- 1952 (3) Section 31A-22-619.6, Coordination of benefits with workers' compensation
- 1953 claim--Health insurer's duty to pay, is repealed on July 1, 2018.
- 1954 (4) Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, is repealed July
- 1955 1, 2015.
- 1956 Section 30. Section 63M-1-2504 is amended to read:
- 1957 **63M-1-2504. Creation of Office of Consumer Health Services -- Duties.**
- 1958 (1) There is created within the Governor's Office of Economic Development the Office
- 1959 of Consumer Health Services.
- 1960 (2) The office shall:
- 1961 (a) in cooperation with the Insurance Department, the Department of Health, and the
- 1962 Department of Workforce Services, and in accordance with the electronic standards developed
- 1963 under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:
- 1964 (i) provides information to consumers about private and public health programs for
- 1965 which the consumer may qualify;
- 1966 (ii) provides a consumer comparison of and enrollment in a health benefit plan posted
- 1967 on the Health Insurance Exchange; and
- 1968 (iii) includes information and a link to enrollment in premium assistance programs and
- 1969 other government assistance programs;
- 1970 (b) contract with one or more private vendors for:
- 1971 (i) administration of the enrollment process on the Health Insurance Exchange,
- 1972 including establishing a mechanism for consumers to compare health benefit plan features on
- 1973 the exchange and filter the plans based on consumer preferences;
- 1974 (ii) the collection of health insurance premium payments made for a single policy by
- 1975 multiple payers, including the policyholder, one or more employers of one or more individuals
- 1976 covered by the policy, government programs, and others; and
- 1977 (iii) establishing a call center in accordance with Subsection ~~(3)~~ (4);
- 1978 (c) assist employers with a free or low cost method for establishing mechanisms for the
- 1979 purchase of health insurance by employees using pre-tax dollars;
- 1980 (d) establish a list on the Health Insurance Exchange of insurance producers who, in

1981 accordance with Section [31A-30-209](#), are appointed producers for the Health Insurance
1982 Exchange; ~~and~~

1983 (e) submit, before November 1, an annual written report to the Business and Labor
1984 Interim Committee and the Health System Reform Task Force regarding the operations of the
1985 Health Insurance Exchange required by this chapter~~[-];~~ and

1986 (f) in accordance with Subsection (3), provide a form to a small employer that certifies:

1987 (i) that the small employer offered a qualified health plan to the small employer's
1988 employees; and

1989 (ii) the period of time within the taxable year in which the small employer maintained
1990 the qualified health plan coverage.

1991 (3) The form required by Subsection (2)(f) shall be provided to a small employer if:

1992 (a) the small employer selected a qualified health plan on the small employer health
1993 exchange created by this section; or

1994 (b) (i) the small employer selected a health plan in the small employer market that is
1995 not offered through the exchange created by this section; and

1996 (ii) the issuer of the health plan selected by the small employer submits to the office, in
1997 a form and manner required by the office:

1998 (A) an affidavit from a member of the American Academy of Actuaries stating that
1999 based on generally accepted actuarial principles and methodologies the issuer's health plan
2000 meets the benefit and actuarial requirements for a qualified health plan under PPACA as
2001 defined in Section [31A-1-301](#); and

2002 (B) an affidavit from the issuer that includes the dates of coverage for the small
2003 employer during the taxable year.

2004 ~~[(3)]~~ (4) A call center established by the office:

2005 (a) shall provide unbiased answers to questions concerning exchange operations, and
2006 plan information, to the extent the plan information is posted on the exchange by the insurer;
2007 and

2008 (b) may not:

2009 (i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

2010 (ii) receive producer compensation through the Health Insurance Exchange; and

2011 (iii) be designated as the default producer for an employer group that enters the Health

2012 Insurance Exchange without a producer.

2013 [~~4~~] (5) The office:

2014 (a) may not:

2015 (i) regulate health insurers, health insurance plans, health insurance producers, or

2016 health insurance premiums charged in the exchange;

2017 (ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

2018 (iii) act as an appeals entity for resolving disputes between a health insurer and an
2019 insured;

2020 (b) may establish and collect a fee for the cost of the exchange transaction in
2021 accordance with Section 63J-1-504 for:

2022 (i) processing an application for a health benefit plan;

2023 (ii) accepting, processing, and submitting multiple premium payment sources;

2024 (iii) providing a mechanism for consumers to filter and compare health benefit plans in
2025 the exchange based on consumer preferences; and

2026 (iv) funding the call center; and

2027 (c) shall separately itemize the fee established under Subsection [~~4~~] (5)(b) as part of
2028 the cost displayed for the employer selecting coverage on the exchange.

2029 Section 31. Section 72-6-107.5 is amended to read:

2030 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**
2031 **insurance coverage.**

2032 (1) For purposes of this section:

2033 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2034 34A-2-104 who:

2035 (i) works at least 30 hours per calendar week; and

2036 (ii) meets employer eligibility waiting requirements for health care insurance which
2037 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
2038 hire.

2039 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

2040 (c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

2041 (d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

2042 (2) (a) Except as provided in Subsection (3), this section applies to contracts entered

2043 into by the department on or after July 1, 2009, for construction or design of highways and to a
2044 prime contractor or to a subcontractor in accordance with Subsection (2)(b).

2045 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2046 amount of \$1,500,000 or greater.

2047 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2048 \$750,000 or greater.

2049 (3) This section does not apply if:

2050 (a) the application of this section jeopardizes the receipt of federal funds;

2051 (b) the contract is a sole source contract; or

2052 (c) the contract is an emergency procurement.

2053 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
2054 or a modification to a contract, when the contract does not meet the initial threshold required
2055 by Subsection (2).

2056 (b) A person who intentionally uses change orders or contract modifications to
2057 circumvent the requirements of Subsection (2) is guilty of an infraction.

2058 (5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
2059 the contractor has and will maintain an offer of qualified health insurance coverage for the
2060 contractor's employees and the employees' dependents during the duration of the contract.

2061 (b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
2062 demonstrate to the department that the subcontractor has and will maintain an offer of qualified
2063 health insurance coverage for the subcontractor's employees and the employees' dependents
2064 during the duration of the contract.

2065 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2066 the duration of the contract is subject to penalties in accordance with administrative rules
2067 adopted by the department under Subsection (6).

2068 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2069 requirements of Subsection (5)(b).

2070 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2071 the duration of the contract is subject to penalties in accordance with administrative rules
2072 adopted by the department under Subsection (6).

2073 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the

2074 requirements of Subsection (5)(a).

2075 (6) The department shall adopt administrative rules:

2076 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2077 (b) in coordination with:

2078 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

2079 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

2080 (iii) the State Building Board in accordance with Section 63A-5-205;

2081 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

2082 (v) a public transit district in accordance with Section 17B-2a-818.5; and

2083 (vi) the Legislature's Administrative Rules Review Committee; and

2084 (c) which establish:

2085 (i) the requirements and procedures a contractor must follow to demonstrate to the

2086 department compliance with this section which shall include:

2087 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or

2088 (b) more than twice in any 12-month period; and

2089 (B) that the actuarially equivalent determination required for qualified health insurance

2090 coverage in Subsection (1) is met by the contractor if the contractor provides the department or

2091 division with a written statement of actuarial equivalency from either:

2092 (I) the Utah Insurance Department;

2093 (II) an actuary selected by the contractor or the contractor's insurer; or

2094 (III) an underwriter who is responsible for developing the employer group's premium

2095 rates;

2096 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

2097 violates the provisions of this section, which may include:

2098 (A) a three-month suspension of the contractor or subcontractor from entering into

2099 future contracts with the state upon the first violation;

2100 (B) a six-month suspension of the contractor or subcontractor from entering into future

2101 contracts with the state upon the second violation;

2102 (C) an action for debarment of the contractor or subcontractor in accordance with

2103 Section 63G-6a-904 upon the third or subsequent violation; and

2104 (D) monetary penalties which may not exceed 50% of the amount necessary to

2105 purchase qualified health insurance coverage for an employee and a dependent of the employee
2106 of the contractor or subcontractor who was not offered qualified health insurance coverage
2107 during the duration of the contract; and

2108 (iii) a website on which the department shall post the benchmark for the qualified
2109 health insurance coverage identified in Subsection (1)(c).

2110 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2111 subcontractor who intentionally violates the provisions of this section shall be liable to the
2112 employee for health care costs that would have been covered by qualified health insurance
2113 coverage.

2114 (ii) An employer has an affirmative defense to a cause of action under Subsection
2115 (7)(a)(i) if:

2116 (A) the employer relied in good faith on a written statement of actuarial equivalency
2117 provided by:

2118 (I) an actuary; or

2119 (II) an underwriter who is responsible for developing the employer group's premium
2120 rates; or

2121 (B) the department determines that compliance with this section is not required under
2122 the provisions of Subsection (3) or (4).

2123 (b) An employee has a private right of action only against the employee's employer to
2124 enforce the provisions of this Subsection (7).

2125 (8) Any penalties imposed and collected under this section shall be deposited into the
2126 Medicaid Restricted Account created in Section [26-18-402](#).

2127 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2128 coverage as required by this section:

2129 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2130 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
2131 Procurement Code; and

2132 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2133 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2134 or construction.

2135 Section 32. Section [79-2-404](#) is amended to read:

2136 **79-2-404. Contracting powers of department -- Health insurance coverage.**

2137 (1) For purposes of this section:

2138 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section
2139 [34A-2-104](#) who:

2140 (i) works at least 30 hours per calendar week; and

2141 (ii) meets employer eligibility waiting requirements for health care insurance which
2142 may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of
2143 hire.

2144 (b) "Health benefit plan" has the same meaning as provided in Section [31A-1-301](#).

2145 (c) "Qualified health insurance coverage" is as defined in Section [26-40-115](#).

2146 (d) "Subcontractor" has the same meaning provided for in Section [63A-5-208](#).

2147 (2) (a) Except as provided in Subsection (3), this section applies a design or
2148 construction contract entered into by, or delegated to, the department or a division, board, or
2149 council of the department on or after July 1, 2009, and to a prime contractor or to a
2150 subcontractor in accordance with Subsection (2)(b).

2151 (b) (i) A prime contractor is subject to this section if the prime contract is in the
2152 amount of \$1,500,000 or greater.

2153 (ii) A subcontractor is subject to this section if a subcontract is in the amount of
2154 \$750,000 or greater.

2155 (3) This section does not apply to contracts entered into by the department or a
2156 division, board, or council of the department if:

2157 (a) the application of this section jeopardizes the receipt of federal funds;

2158 (b) the contract or agreement is between:

2159 (i) the department or a division, board, or council of the department; and

2160 (ii) (A) another agency of the state;

2161 (B) the federal government;

2162 (C) another state;

2163 (D) an interstate agency;

2164 (E) a political subdivision of this state; or

2165 (F) a political subdivision of another state; or

2166 (c) the contract or agreement is:

2167 (i) for the purpose of disbursing grants or loans authorized by statute;

2168 (ii) a sole source contract; or

2169 (iii) an emergency procurement.

2170 (4) (a) This section does not apply to a change order as defined in Section [63G-6a-103](#),
2171 or a modification to a contract, when the contract does not meet the initial threshold required
2172 by Subsection (2).

2173 (b) A person who intentionally uses change orders or contract modifications to
2174 circumvent the requirements of Subsection (2) is guilty of an infraction.

2175 (5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department
2176 that the contractor has and will maintain an offer of qualified health insurance coverage for the
2177 contractor's employees and the employees' dependents during the duration of the contract.

2178 (b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor
2179 shall demonstrate to the department that the subcontractor has and will maintain an offer of
2180 qualified health insurance coverage for the subcontractor's employees and the employees'
2181 dependents during the duration of the contract.

2182 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
2183 the duration of the contract is subject to penalties in accordance with administrative rules
2184 adopted by the department under Subsection (6).

2185 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
2186 requirements of Subsection (5)(b).

2187 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
2188 the duration of the contract is subject to penalties in accordance with administrative rules
2189 adopted by the department under Subsection (6).

2190 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
2191 requirements of Subsection (5)(a).

2192 (6) The department shall adopt administrative rules:

2193 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

2194 (b) in coordination with:

2195 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

2196 (ii) a public transit district in accordance with Section [17B-2a-818.5](#);

2197 (iii) the State Building Board in accordance with Section [63A-5-205](#);

2198 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
2199 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
2200 (vi) the Legislature's Administrative Rules Review Committee; and
2201 (c) which establish:
2202 (i) the requirements and procedures a contractor must follow to demonstrate
2203 compliance with this section to the department which shall include:
2204 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
2205 (b) more than twice in any 12-month period; and
2206 (B) that the actuarially equivalent determination required for qualified health insurance
2207 coverage in Subsection (1) is met by the contractor if the contractor provides the department or
2208 division with a written statement of actuarial equivalency from either:
2209 (I) the Utah Insurance Department;
2210 (II) an actuary selected by the contractor or the contractor's insurer; or
2211 (III) an underwriter who is responsible for developing the employer group's premium
2212 rates;
2213 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
2214 violates the provisions of this section, which may include:
2215 (A) a three-month suspension of the contractor or subcontractor from entering into
2216 future contracts with the state upon the first violation;
2217 (B) a six-month suspension of the contractor or subcontractor from entering into future
2218 contracts with the state upon the second violation;
2219 (C) an action for debarment of the contractor or subcontractor in accordance with
2220 Section 63G-6a-904 upon the third or subsequent violation; and
2221 (D) monetary penalties which may not exceed 50% of the amount necessary to
2222 purchase qualified health insurance coverage for an employee and a dependent of an employee
2223 of the contractor or subcontractor who was not offered qualified health insurance coverage
2224 during the duration of the contract; and
2225 (iii) a website on which the department shall post the benchmark for the qualified
2226 health insurance coverage identified in Subsection (1)(c).
2227 (7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
2228 subcontractor who intentionally violates the provisions of this section shall be liable to the

2229 employee for health care costs that would have been covered by qualified health insurance
2230 coverage.

2231 (ii) An employer has an affirmative defense to a cause of action under Subsection
2232 (7)(a)(i) if:

2233 (A) the employer relied in good faith on a written statement of actuarial equivalency
2234 provided by:

2235 (I) an actuary; or

2236 (II) an underwriter who is responsible for developing the employer group's premium
2237 rates; or

2238 (B) the department determines that compliance with this section is not required under
2239 the provisions of Subsection (3) or (4).

2240 (b) An employee has a private right of action only against the employee's employer to
2241 enforce the provisions of this Subsection (7).

2242 (8) Any penalties imposed and collected under this section shall be deposited into the
2243 Medicaid Restricted Account created in Section [26-18-402](#).

2244 (9) The failure of a contractor or subcontractor to provide qualified health insurance
2245 coverage as required by this section:

2246 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
2247 or contractor under Section [63G-6a-1603](#) or any other provision in Title 63G, Chapter 6a, Utah
2248 Procurement Code; and

2249 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
2250 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
2251 or construction.

2252 Section 33. **Effective date.**

2253 (1) Except as provided in Subsection (2), this bill takes effect May 13, 2014.

2254 (2) The amendments to Section [63I-1-231](#) (Effective 07/01/14) take effect on July 1,
2255 2014.

Legislative Review Note
as of 2-11-14 11:02 AM

Office of Legislative Research and General Counsel