1 # HEALTH SYSTEM REFORM AMENDMENTS

2 2013 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: Evan J. Vickers

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7 **LONG TITLE**

8 **General Description:**

9 This bill amends provisions in the Insurance Code and in Governor's Programs related

10 to health system reform.

11 **Highlighted Provisions:**

12 This bill:

13 ▸ authorizes the insurance commissioner to regulate the state insurance market as it

14 transitions to new rating practices and health plan requirements of federal law;

15 ▸ gives insurance producers and agents the authority to sell, solicit, and negotiate

16 health insurance on a federal health insurance exchange;

17 ▸ permits an insurer to pass through commission payments from an insured to a

18 producer;

19 ▸ establishes the requirements for a navigator license;

20 ▸ amends definitions in the Individual, Small Employer and Group Health Insurance

21 Act;

22 ▸ establishes separate risk pools for the individual health insurance market and the

23 small group health insurance market;

24 ▸ amends discontinuation and nonrenewal limitations and conditions;

25 ▸ amends small employer participation and contribution requirements;

26 ▸ amends provisions regarding actuarial review of rates;

27 ▸ gives the commissioner administrative rulemaking authority to facilitate state

28 regulation of insurers, qualified health plans, and the health insurance market when

29 federal insurance exchanges begin operating in the state, including:

30 • rate review and approval; and
31 • creating uniform open enrollment periods for the individual health
32 insurance market;
33 ▸ removes the requirement that a carrier in Utah's defined contribution arrangement
34 market (Avenue H) must offer certain health benefit products on Avenue H;
35 ▸ authorizes free-standing dental and vision plans on Utah's Avenue H;
36 ▸ extends the sunset date for the Risk Adjuster Board for the defined contribution
37 arrangement market;
38 ▸ removes the rating parity requirement for plans offered on Avenue H;
39 ▸ establishes regulations for stop-loss and re-insurance insurers for small employers;
40 ▸ establishes the general insurance laws that apply to small employer stop-loss
41 insurers;
42 ▸ applies the regulations to stop-loss contracts issued or renewed on or after July 1,
43 2013;
44 ▸ gives the commissioner administrative rulemaking authority.
45 ▸ makes technical amendments;
46 ▸ amends executive branch reporting requirements related to the Patient Protection
47 and Affordable Care Act (PPACA) implementation; and
48 ▸ reauthorizes the Health System Reform Task Force until December 30, 2015.
49 **Money Appropriated in this Bill:**
50 This bill appropriates in fiscal year 2013-14:
51 ▸ to the Legislature-Senate as a one-time appropriation:
52 • from the General Fund, One-time, $30,000
53 ▸ to the Legislature-House as a one-time appropriation:
54 • from the General Fund, One-time, $52,000.
55 **Other Special Clauses:**
56 This bill provides an effective date.
57 This bill provides a repeal date.

58 **Utah Code Sections Affected:**
59 AMENDS:
60 **31A-2-212**, as last amended by Laws of Utah 2011, Chapters 284 and 400
61 **31A-23a-501**, as last amended by Laws of Utah 2012, Chapter 279
62 **31A-30-104**, as last amended by Laws of Utah 2011, Chapter 400
63 **31A-30-105**, as last amended by Laws of Utah 2011, Chapter 284
64 **31A-30-107.3**, as last amended by Laws of Utah 2011, Chapter 297
65 **31A-30-112**, as last amended by Laws of Utah 2012, Chapter 253
66 **31A-30-115**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
67 **31A-30-208**, as last amended by Laws of Utah 2011, Chapter 400
68 **63I-2-231 (Superseded 07/01/13)**, as last amended by Laws of Utah 2012, Chapter 279
69 **63I-2-231 (Effective 07/01/13)**, as last amended by Laws of Utah 2012, Chapters 243
70 and 279
71 **63M-1-2505.5**, as enacted by Laws of Utah 2010, Chapter 51
72 ENACTS:
73 **31A-23a-208**, Utah Code Annotated 1953
74 **31A-23b-101**, Utah Code Annotated 1953
75 **31A-23b-102**, Utah Code Annotated 1953
76 **31A-23b-201**, Utah Code Annotated 1953
77 **31A-23b-202**, Utah Code Annotated 1953
78 **31A-23b-203**, Utah Code Annotated 1953
79 **31A-23b-204**, Utah Code Annotated 1953
80 **31A-23b-205**, Utah Code Annotated 1953
81 **31A-23b-206**, Utah Code Annotated 1953
82 **31A-23b-207**, Utah Code Annotated 1953
83 **31A-23b-208**, Utah Code Annotated 1953
84 **31A-23b-209**, Utah Code Annotated 1953
85 **31A-23b-210**, Utah Code Annotated 1953

86 **31A-23b-211**, Utah Code Annotated 1953
87 **31A-23b-301**, Utah Code Annotated 1953
88 **31A-23b-401**, Utah Code Annotated 1953
89 **31A-23b-402**, Utah Code Annotated 1953
90 **31A-23b-403**, Utah Code Annotated 1953
91 **31A-23b-404**, Utah Code Annotated 1953
92 **31A-30-117**, Utah Code Annotated 1953
93 **31A-30-202.6**, Utah Code Annotated 1953
94 **31A-43-101**, Utah Code Annotated 1953
95 **31A-43-102**, Utah Code Annotated 1953
96 **31A-43-201**, Utah Code Annotated 1953
97 **31A-43-202**, Utah Code Annotated 1953
98 **31A-43-301**, Utah Code Annotated 1953
99 **31A-43-302**, Utah Code Annotated 1953
100 **31A-43-303**, Utah Code Annotated 1953
101 **31A-43-304**, Utah Code Annotated 1953
102 **Uncodified Material Affected:**
103 ENACTS UNCODIFIED MATERIAL
104

105 *Be it enacted by the Legislature of the state of Utah:*
106 Section 1. Section **31A-2-212** is amended to read:
107 **31A-2-212. Miscellaneous duties.**
108 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to
109 do business in Utah, and when the commissioner begins a proceeding against an insurer under
110 Chapter 27a, Insurer Receivership Act, the commissioner:
111 (a) shall notify by mail the producers of the person or insurer of whom the
112 commissioner has record; and
113 (b) may publish notice of the order or proceeding in any manner the commissioner

114 considers necessary to protect the rights of the public.
115 (2) When required for evidence in a legal proceeding, the commissioner shall furnish a
116 certificate of authority of a licensee to transact the business of insurance in Utah on any
117 particular date. The court or other officer shall receive the certificate of authority in lieu of the
118 commissioner's testimony.
119 (3) (a) On the request of an insurer authorized to do a surety business, the
120 commissioner shall furnish a copy of the insurer's certificate of authority to a designated public
121 officer in this state who requires that certificate of authority before accepting a bond.
122 (b) The public officer described in Subsection (3)(a) shall file the certificate of
123 authority furnished under Subsection (3)(a).
124 (c) After a certified copy of a certificate of authority is furnished to a public officer, it
125 is not necessary, while the certificate of authority remains effective, to attach a copy of it to any
126 instrument of suretyship filed with that public officer.
127 (d) Whenever the commissioner revokes the certificate of authority or begins a
128 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a
129 surety business, the commissioner shall immediately give notice of that action to each public
130 officer who is sent a certified copy under this Subsection (3).
131 (4) (a) The commissioner shall immediately notify every judge and clerk of the courts
132 of record in the state when:
133 (i) an authorized insurer doing a surety business:
134 (A) files a petition for receivership; or
135 (B) is in receivership; or
136 (ii) the commissioner has reason to believe that the authorized insurer doing surety
137 business:
138 (A) is in financial difficulty; or
139 (B) has unreasonably failed to carry out any of its contracts.
140 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the
141 judges and clerks to notify and require a person that files with the court a bond on which the

142 authorized insurer doing surety business is surety to immediately file a new bond with a new
143 surety.
144 (5) (a) The commissioner shall report to the Legislature in accordance with Section
145 63M-1-2505.5 prior to adopting a rule authorized by Subsection (5)(b).
146 (b) The commissioner shall require an insurer that issues, sells, renews, or offers health
147 insurance coverage in this state to comply with[~~:(a) the Health Insurance Portability and~~
148 ~~Accountability Act, Pub. L. No. 104-191; and(b) subject to Section 63M-1-2505.5, and to the~~
149 ~~extent required or applicable under the provisions of the Patient Protection and Affordable~~
150 ~~Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub.~~
151 ~~L. No. 111-152,~~] the provisions of PPACA and administrative rules adopted by the
152 commissioner related to regulation of health benefit plans, including:
153 (i) lifetime and annual limits;
154 (ii) prohibition of rescissions;
155 (iii) coverage of preventive health services;
156 (iv) coverage for a child or dependent;
157 (v) pre-existing condition coverage for children;
158 (vi) insurer transparency of consumer information including plan disclosures, uniform
159 coverage documents, and standard definitions;
160 (vii) premium rate reviews;
161 (viii) essential health benefits;
162 (ix) provider choice;
163 (x) waiting periods; [~~and~~]
164 (xi) appeals processes[~~.~~];
165 (xii) rating restrictions;
166 (xiii) uniform applications and notice provisions; and
167 (xiv) certification and regulation of qualified health plans.
168 (c) The commissioner shall preserve state control over:
169 (i) the health insurance market in the state;

170 (ii) qualified health plans offered in the state; and
171 (iii) the conduct of navigators, producers, and in-person assisters operating in the state.
172 (d) If the state enters into an agreement with the United States Department of Health
173 and Human Services in which the state operates health insurance plan management, the
174 commissioner may:
175 (i) for fiscal year 2014, hire one temporary and two permanent full-time employees to
176 be funded through the department's existing budget; and
177 (ii) for fiscal year 2015, hire two permanent full-time employees funded through the
178 Insurance Department Restricted Account, subject to appropriations from the Legislature and
179 approval by the governor.
180 Section 2. Section **31A-23a-208** is enacted to read:
181 **31A-23a-208. Producer and agency authority in health insurance exchange.**
182 A producer or agency licensed under this chapter, with a line of authority that permits
183 the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized
184 to sell, negotiate, or solicit qualified health plans offered on an exchange that is:
185 (1) operated in the state; or
186 (2) operated in the state and certified by the United States Department of Health and
187 Human Services as a:
188 (a) state-based exchange under PPACA;
189 (b) a federally facilitated exchange under PPACA; or
190 (c) a partnership exchange under PPACA.
191 Section 3. Section **31A-23a-501** is amended to read:
192 **31A-23a-501. Licensee compensation.**
193 (1) As used in this section:
194 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
195 licensee from:
196 (i) commission amounts deducted from insurance premiums on insurance sold by or
197 placed through the licensee; or

198 (ii) commission amounts received from an insurer or another licensee as a result of the
199 sale or placement of insurance.
200 (b) (i) "Compensation from an insurer or third party administrator" means
201 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
202 gifts, prizes, or any other form of valuable consideration:
203 (A) whether or not payable pursuant to a written agreement; and
204 (B) received from:
205 (I) an insurer; or
206 (II) a third party to the transaction for the sale or placement of insurance.
207 (ii) "Compensation from an insurer or third party administrator" does not mean
208 compensation from a customer that is:
209 (A) a fee or pass-through costs as provided in Subsection (1)(e); or
210 (B) a fee or amount collected by or paid to the producer that does not exceed an
211 amount established by the commissioner by administrative rule.
212 (c) (i) "Customer" means:
213 (A) the person signing the application or submission for insurance; or
214 (B) the authorized representative of the insured actually negotiating the placement of
215 insurance with the producer.
216 (ii) "Customer" does not mean a person who is a participant or beneficiary of:
217 (A) an employee benefit plan; or
218 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
219 negotiated by the producer or affiliate.
220 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
221 benefit of a licensee other than commission compensation.
222 (ii) "Noncommission compensation" does not include charges for pass-through costs
223 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.
224 (e) "Pass-through costs" include:
225 (i) costs for copying documents to be submitted to the insurer; and

226 (ii) bank costs for processing cash or credit card payments.
227 (2) A licensee may receive from an insured or from a person purchasing an insurance
228 policy, noncommission compensation if the noncommission compensation is stated on a
229 separate, written disclosure.
230 (a) The disclosure required by this Subsection (2) shall:
231 (i) include the signature of the insured or prospective insured acknowledging the
232 noncommission compensation;
233 (ii) clearly specify the amount or extent of the noncommission compensation; and
234 (iii) be provided to the insured or prospective insured before the performance of the
235 service.
236 (b) Noncommission compensation shall be:
237 (i) limited to actual or reasonable expenses incurred for services; and
238 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
239 business or for a specific service or services.
240 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained
241 by any licensee who collects or receives the noncommission compensation or any portion of
242 the noncommission compensation.
243 (d) All accounting records relating to noncommission compensation shall be
244 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.
245 (3) (a) A licensee may receive noncommission compensation when acting as a
246 producer for the insured in connection with the actual sale or placement of insurance if:
247 (i) the producer and the insured have agreed on the producer's noncommission
248 compensation; and
249 (ii) the producer has disclosed to the insured the existence and source of any other
250 compensation that accrues to the producer as a result of the transaction.
251 (b) The disclosure required by this Subsection (3) shall:
252 (i) include the signature of the insured or prospective insured acknowledging the
253 noncommission compensation;

254 (ii) clearly specify the amount or extent of the noncommission compensation and the
255 existence and source of any other compensation; and
256 (iii) be provided to the insured or prospective insured before the performance of the
257 service.
258 (c) The following additional noncommission compensation is authorized:
259 (i) compensation received by a producer of a compensated corporate surety who under
260 procedures approved by a rule or order of the commissioner is paid by surety bond principal
261 debtors for extra services;
262 (ii) compensation received by an insurance producer who is also licensed as a public
263 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
264 claim adjustment, so long as the producer does not receive or is not promised compensation for
265 aiding in the claim adjustment prior to the occurrence of the claim;
266 (iii) compensation received by a consultant as a consulting fee, provided the consultant
267 complies with the requirements of Section 31A-23a-401; or
268 (iv) other compensation arrangements approved by the commissioner after a finding
269 that they do not violate Section 31A-23a-401 and are not harmful to the public.
270 (d) Subject to Section 31A-23a-402.5, a producer for the insured may receive
271 compensation from an insured through an insurer, for the negotiation and sale of a health
272 benefit plan, if there is a separate written agreement between the insured and the licensee for
273 the compensation. An insurer who passes through the compensation from the insured to the
274 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or
275 commission compensation to the licensee.
276 (4) (a) For purposes of this Subsection (4), "producer" includes:
277 (i) a producer;
278 (ii) an affiliate of a producer; or
279 (iii) a consultant.
280 (b) A producer may not accept or receive any compensation from an insurer or third
281 party administrator for the initial placement of a health benefit plan, other than a hospital

282 confinement indemnity policy, unless prior to the customer's initial purchase of the health
283 benefit plan the producer discloses in writing to the customer that the producer will receive
284 compensation from the insurer or third party administrator for the placement of insurance,
285 including the amount or type of compensation known to the producer at the time of the
286 disclosure.
287 (c) A producer shall:
288 (i) obtain the customer's signed acknowledgment that the disclosure under Subsection
289 (4)(b) was made to the customer; or
290 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to
291 the customer; and
292 (B) keep the signed statement on file in the producer's office while the health benefit
293 plan placed with the customer is in force.
294 (d) (i) A licensee who collects or receives any part of the compensation from an insurer
295 or third party administrator in a manner that facilitates an audit shall, while the health benefit
296 plan placed with the customer is in force, maintain a copy of:
297 (A) the signed acknowledgment described in Subsection (4)(c)(i); or
298 (B) the signed statement described in Subsection (4)(c)(ii).
299 (ii) The standard application developed in accordance with Section 31A-22-635 shall
300 include a place for a producer to provide the disclosure required by this Subsection (4), and if
301 completed, shall satisfy the requirement of Subsection (4)(d)(i).
302 (e) Subsection (4)(c) does not apply to:
303 (i) a person licensed as a producer who acts only as an intermediary between an insurer
304 and the customer's producer, including a managing general agent; or
305 (ii) the placement of insurance in a secondary or residual market.
306 (5) This section does not alter the right of any licensee to recover from an insured the
307 amount of any premium due for insurance effected by or through that licensee or to charge a
308 reasonable rate of interest upon past-due accounts.
309 (6) This section does not apply to bail bond producers or bail enforcement agents as

310 defined in Section 31A-35-102.
311 (7) A licensee may not receive noncommission compensation from an insured or
312 enrollee for providing a service or engaging in an act that is required to be provided or
313 performed in order to receive commission compensation, except for the surplus lines
314 transactions that do not receive commissions.
315 Section 4. Section **31A-23b-101** is enacted to read:
316 **CHAPTER 23b. NAVIGATOR LICENSE ACT**
317 **Part 1. General Provisions**
318 **31A-23b-101. Title.**
319 This chapter is known as the "Navigator License Act."
320 Section 5. Section **31A-23b-102** is enacted to read:
321 **31A-23b-102. Definitions.**
322 As used in this chapter:
323 (1) "Compensation" is as defined in:
324 (a) Subsections 31A-23a-501(1)(a), (b), and (d); and
325 (b) PPACA.
326 (2) "Enroll" and "enrollment" mean to:
327 (a) (i) obtain personally identifiable information about an individual; and
328 (ii) inform an individual about accident and health insurance plans or public programs
329 offered on an exchange;
330 (b) solicit insurance; or
331 (c) submit to the exchange:
332 (i) personally identifiable information about an individual; and
333 (ii) an individual's selection of a particular accident and health insurance plan or public
334 program offered on the exchange.
335 (3) (a) "Exchange" means an online marketplace:
336 (i) for an individual to purchase a qualified health plan; and
337 (ii) that is certified by the United States Department of Health and Human Services as

338 either a state-based exchange or a federally facilitated exchange under PPACA.

339 (b) (i) "Exchange" does not include:

340 (A) an online marketplace for the purchase of health insurance if the online

341 marketplace is not a certified exchange under PPACA; or

342 (B) except as provided in Subsection (3)(b)(ii), an online marketplace for small

343 employers that is certified as a PPACA compliant SHOP exchange.

344 (ii) For purposes of this chapter, exchange does include a small employer SHOP

345 exchange described under Subsection (3)(b)(i)(B) if:

346 (A) federal regulations under PPACA require a small employer exchange to allow

347 navigators to assist small employers and their employees with selection of qualified health

348 plans on a small employer exchange; and

349 (B) the state has not entered into an agreement with the United States Department of

350 Health and Human Services that permits the state to limit the scope of practice of navigators to

351 only the individual PPACA exchange.

352 (4) "Navigator":

353 (a) means a person who facilitates enrollment in an exchange by offering to assist, or

354 who advertises any services to assist, with:

355 (i) the selection of and enrollment in a qualified health plan or a public program

356 offered on an exchange; or

357 (ii) applying for premium subsidies through an exchange; and

358 (b) includes a person who is an in-person assister or an application assister as described

359 in:

360 (i) federal regulations or guidance issued under PPACA; and

361 (ii) the state exchange blueprint published by the Center for Consumer Information and

362 Insurance Oversight within the Centers for Medicare and Medicaid Services in the United

363 States Department of Health and Human Services.

364 (5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

365 (6) "Public programs" means the state Medicaid program in Title 26, Chapter 18,

366 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.
367 (7) "Solicit" is as defined in Section 31A-23a-102.
368 Section 6. Section **31A-23b-201** is enacted to read:
369 **Part 2. Licensing**
370 **31A-23b-201. Requirement of license.**
371 (1) (a) Except as provided in Section 31A-23b-211, a person may not perform, offer to
372 perform, or advertise any service as a navigator in the state, without:
373 (i) a valid navigator license issued under this chapter; or
374 (ii) a valid producer license under Subsection 31A-23a-106(2)(a) with a line of
375 authority that permits the person to sell, negotiate, or solicit accident and health insurance.
376 (b) A person may not utilize the services of another as a navigator if that person knows
377 or should know that the other person does not have a license as required by law.
378 (2) An insurance contract is not invalid as a result of a violation of this section.
379 Section 7. Section **31A-23b-202** is enacted to read:
380 **31A-23b-202. Qualifications for a license.**
381 (1) (a) The commissioner shall issue or renew a license to a person to act as a navigator
382 if the person:
383 (i) satisfies the:
384 (A) application requirements under Section 31A-23b-203;
385 (B) character requirements under Section 31A-23b-204;
386 (C) examination and training requirements under Section 31A-23b-205; and
387 (D) continuing education requirements under Section 31A-23b-206;
388 (ii) certifies that, to the extent applicable, the applicant:
389 (A) is in compliance with the surety bond requirements of Section 31A-23b-207; and
390 (B) will maintain compliance with Section 31A-23b-207 during the period for which
391 the license is issued or renewed; and
392 (iii) has not committed an act that is a ground for denial, suspension, or revocation as
393 provided in Section 31A-23b-401.

394 (b) A license issued under this chapter is valid for two years.
395 (2) (a) A person shall report to the commissioner:
396 (i) an administrative action taken against the person, including a denial of a new or
397 renewal license application:
398 (A) in another jurisdiction; or
399 (B) by another regulatory agency in this state; and
400 (ii) a criminal prosecution taken against the person in any jurisdiction.
401 (b) The report required by Subsection (2)(a) shall be filed:
402 (i) at the time the person files the application for an individual or agency license; and
403 (ii) for an action or prosecution that occurs on or after the day on which the person files
404 the application:
405 (A) for an administrative action, within 30 days of the final disposition of the
406 administrative action; or
407 (B) for a criminal prosecution, within 30 days of the initial appearance before a court.
408 (c) The report required by Subsection (2)(a) shall include a copy of the complaint or
409 other relevant legal documents related to the action or prosecution described in Subsection
410 (2)(a).
411 (3) (a) The department may:
412 (i) require a person applying for a license to submit to a criminal background check as
413 a condition of receiving a license; or
414 (ii) accept a background check conducted by another organization.
415 (b) A person, if required to submit to a criminal background check under Subsection
416 (3)(a), shall:
417 (i) submit a fingerprint card in a form acceptable to the department; and
418 (ii) consent to a fingerprint background check by:
419 (A) the Utah Bureau of Criminal Identification; and
420 (B) the Federal Bureau of Investigation.
421 (c) For a person who submits a fingerprint card and consents to a fingerprint

422 background check under Subsection (3)(b), the department may request:
423 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
424 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
425 (ii) complete Federal Bureau of Investigation criminal background checks through the
426 national criminal history system.
427 (d) Information obtained by the department from the review of criminal history records
428 received under this Subsection (3) shall be used by the department for the purposes of:
429 (i) determining if a person satisfies the character requirements under Section
430 31A-23b-204 for issuance or renewal of a license;
431 (ii) determining if a person failed to maintain the character requirements under Section
432 31A-23b-204; and
433 (iii) preventing a person who violates the federal Violent Crime Control and Law
434 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or
435 in-person assistor in the state.
436 (e) If the department requests the criminal background information, the department
437 shall:
438 (i) pay to the Department of Public Safety the costs incurred by the Department of
439 Public Safety in providing the department criminal background information under Subsection
440 (3)(c)(i);
441 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
442 of Investigation in providing the department criminal background information under
443 Subsection (3)(c)(ii); and
444 (iii) charge the person applying for a license a fee equal to the aggregate of Subsections
445 (3)(e)(i) and (ii).
446 (4) The commissioner may deny an application for a license under this chapter if the
447 person applying for the license:
448 (a) fails to satisfy the requirements of this section; or
449 (b) commits an act that is grounds for denial, suspension, or revocation as set forth in

450 Section 31A-23b-401.

451 Section 8. Section **31A-23b-203** is enacted to read:

452 **31A-23b-203. Application for individual license -- Application for agency license.**

453 (1) This section applies to an initial or renewal license as a navigator.

454 (2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an

455 individual shall:

456 (i) file an application for an initial or renewal individual license with the commissioner

457 on forms and in a manner the commissioner prescribes; and

458 (ii) pay a license fee that is not refunded if the application:

459 (A) is denied; or

460 (B) is incomplete when filed and is never completed by the applicant.

461 (b) An application described in this Subsection (2) shall provide:

462 (i) information about the applicant's identity;

463 (ii) the applicant's Social Security number;

464 (iii) the applicant's personal history, experience, education, and business record;

465 (iv) whether the applicant is 18 years of age or older;

466 (v) whether the applicant has committed an act that is a ground for denial, suspension,

467 or revocation as set forth in Section 31A-23b-401 or 31A-23b-402;

468 (vi) that the applicant complies with the surety bond requirements of Section

469 31A-23b-207;

470 (vii) that the applicant completed the training requirements in Section 31A-23b-205;

471 and

472 (viii) any other information the commissioner reasonably requires.

473 (3) The commissioner may require a document reasonably necessary to verify the

474 information contained in an application filed under this section.

475 (4) An applicant's Social Security number contained in an application filed under this

476 section is a private record under Section 63G-2-302.

477 (5) (a) Subject to Subsection (5)(b), to obtain or renew a navigator agency license, a

478 person shall:
479 (i) file an application for an initial or renewal navigator agency license with the
480 commissioner on forms and in a manner the commissioner prescribes; and
481 (ii) pay a license fee that is not refunded if the application:
482 (A) is denied; or
483 (B) is incomplete when filed and is never completed by the applicant.
484 (b) An application described in Subsection (5)(a) shall provide:
485 (i) information about the applicant's identity;
486 (ii) the applicant's federal employer identification number;
487 (iii) the designated responsible licensed individual;
488 (iv) the identity of the owners, partners, officers, and directors;
489 (v) whether the applicant, or individual identified in Subsections (5)(b)(iii) and (iv),
490 has committed an act that is a ground for denial, suspension, or revocation as set forth in
491 Section 31A-23b-401; and
492 (vi) any other information the commissioner reasonably requires.
493 Section 9. Section **31A-23b-204** is enacted to read:
494 **31A-23b-204. Character requirements.**
495 An applicant for a license under this chapter shall demonstrate to the commissioner
496 that:
497 (1) the applicant has the intent, in good faith, to engage in the practice of a navigator as
498 the license would permit;
499 (2) (a) if a natural person, the applicant is competent and trustworthy; or
500 (b) if the applicant is an agency:
501 (i) the partners, directors, or principal officers or persons having comparable powers
502 are trustworthy; and
503 (ii) that it will transact business in a way that the acts that may only be performed by a
504 licensed navigator are performed only by a natural person who is licensed under this chapter, or
505 Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance

506 Intermediaries;
507 (3) the applicant intends to comply with the surety bond requirements of Section
508 31A-23b-207;
509 (4) if a natural person, the applicant is at least 18 years of age; and
510 (5) the applicant does not have a conflict of interest as defined by regulations issued
511 under PPACA.
512 Section 10. Section **31A-23b-205** is enacted to read:
513 **31A-23b-205. Examination and training requirements.**
514 (1) The commissioner may require applicants for a license to pass an examination and
515 complete a training program as a requirement for a license.
516 (2) The examination described in Subsection (1) shall reasonably relate to:
517 (a) the duties and functions of a navigator;
518 (b) requirements for navigators as established by federal regulation under PPACA; and
519 (c) other requirements that may be established by the commissioner by administrative
520 rule.
521 (3) The examination may be administered by the commissioner or as otherwise
522 specified by administrative rule.
523 (4) The training required by Subsection (1) shall be approved by the commissioner and
524 shall include:
525 (a) accident and health insurance plans;
526 (b) qualifications for and enrollment in public programs;
527 (c) qualifications for and enrollment in premium subsidies;
528 (d) cultural and linguistic competence;
529 (e) conflict of interest standards;
530 (f) exchange functions; and
531 (g) other requirements that may be adopted by the commissioner by administrative
532 rule.
533 (5) This section applies only to applicants who are natural persons.

534 Section 11. Section **31A-23b-206** is enacted to read:

535 **31A-23b-206. Continuing education requirements.**

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

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

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

542 (i) accident and health insurance;

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

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

545 (iv) cultural competency;

546 (v) conflict of interest standards; and

547 (vi) other exchange functions.

548 (3) (a) Continuing education requirements shall require:

549 (i) that a licensee complete 24 credit hours of continuing education for every two-year
550 licensing period;

551 (ii) that 3 of the 24 credit hours described in Subsection (3)(a)(i) be ethics courses; and

552 (iii) that the licensee complete at least half of the required hours through classroom
553 hours of insurance and exchange related instruction.

554 (b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be
555 obtained through:

556 (i) classroom attendance;

557 (ii) home study;

558 (iii) watching a video recording;

559 (iv) experience credit; or

560 (v) another method approved by rule.

561 (c) A licensee may obtain continuing education hours at any time during the two-year

562 license period.

563 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

564 commissioner shall, by rule:

565 (i) publish a list of insurance professional designations whose continuing education

566 requirements can be used to meet the requirements for continuing education under Subsection

567 (3)(b); and

568 (ii) authorize one or more continuing education providers, including a state or national

569 professional producer or consultant associations, to:

570 (A) offer a qualified program on a geographically accessible basis; and

571 (B) collect a reasonable fee for funding and administration of a continuing education

572 program, subject to the review and approval of the commissioner.

573 (4) The commissioner shall approve a continuing education provider or a continuing

574 education course that satisfies the requirements of this section.

575 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

576 commissioner shall by rule establish the procedures for continuing education provider

577 registration and course approval.

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

579 (7) A navigator shall keep documentation of completing the continuing education

580 requirements of this section for two years after the end of the two-year licensing period to

581 which the continuing education applies.

582 Section 12. Section **31A-23b-207** is enacted to read:

583 **31A-23b-207. Requirement to obtain surety bond.**

584 (1) (a) Except as provided in Subsections (1)(b)(ii) and (2), a navigator shall obtain a

585 surety bond in an amount designated by the commissioner by administrative rule to cover the

586 legal liability of the navigator as the result of an erroneous act or failure to act in the navigator's

587 capacity as a navigator.

588 (b) The navigator shall:

589 (i) maintain a surety bond at all times during the term of the navigator's license; or

590 (ii) demonstrate to the commissioner that the navigator is capable of covering a legal
591 liability for erroneous acts or failure to act in a manner approved by the commissioner.
592 (2) A navigator is not required to obtain and maintain a surety bond during a period in
593 which the navigator's scope of practice is limited to assisting individuals with:
594 (a) enrollment in public programs; and
595 (b) qualification for premium and cost sharing subsidies.
596 Section 13. Section **31A-23b-208** is enacted to read:
597 **31A-23b-208. Form and contents of license.**
598 (1) A license issued under this chapter shall be in the form the commissioner prescribes
599 and shall set forth:
600 (a) the name and address of the licensee;
601 (b) the date of license issuance; and
602 (c) any other information the commissioner considers necessary.
603 (2) A licensee under this chapter doing business under a name other than the licensee's
604 legal name shall notify the commissioner before using the assumed name in this state.
605 Section 14. Section **31A-23b-209** is enacted to read:
606 **31A-23b-209. Agency designations.**
607 (1) An organization shall be licensed as a navigator agency if the organization acts as a
608 navigator.
609 (2) A navigator agency that does business in the state shall designate an individual who
610 is licensed under this chapter to act on the agency's behalf.
611 (3) A navigator agency shall report to the commissioner, at intervals and in the form
612 the commissioner establishes by rule:
613 (a) a new designation under Subsection (2); and
614 (b) a terminated designation under Subsection (2).
615 (4) (a) A navigator agency licensed under this chapter shall report to the commissioner
616 the cause of termination of a designation if:
617 (i) the reason for termination is a reason described in Subsection 31A-23b-401(4)(b);

618 or

619 (ii) the navigator agency has knowledge that the individual licensee engaged in an

620 activity described in Subsection 31A-23b-401(4)(b) by:

621 (A) a court;

622 (B) a government body; or

623 (C) a self-regulatory organization, which the commissioner may define by rule made in

624 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

625 (b) The information provided to the commissioner under Subsection (4)(a) is a private

626 record under Title 63G, Chapter 2, Government Records Access and Management Act.

627 (c) A navigator agency is immune from civil action, civil penalty, or damages if the

628 agency complies in good faith with this Subsection (4) by reporting to the commissioner the

629 cause of termination of a designation.

630 (d) A navigator agency is not immune from an action or resulting penalty imposed on

631 the reporting agency as a result of proceedings brought by or on behalf of the department if the

632 action is based on evidence other than the report submitted in compliance with this Subsection

633 (4).

634 (5) A navigator agency licensed under this chapter may act in a capacity for which it is

635 licensed only through an individual who is licensed under this chapter to act in the same

636 capacity.

637 (6) A navigator agency licensed under this chapter shall designate and report to the

638 commissioner, in accordance with any rule made by the commissioner, the name of the

639 designated responsible licensed individual who has authority to act on behalf of the navigator

640 agency in the matters pertaining to compliance with this title and orders of the commissioner.

641 (7) If a navigator agency designates a licensee in reports submitted under Subsection

642 (3) or (6), there is a rebuttable presumption that the designated licensee acts on behalf of the

643 navigator agency.

644 (8) (a) When a license is held by a navigator agency, both the navigator agency itself

645 and any individual designated under the navigator agency license are considered the holders of

646 the navigator agency license for purposes of this section.
647 (b) If an individual designated under the navigator agency license commits an act or
648 fails to perform a duty that is a ground for suspending, revoking, or limiting the navigator
649 agency license, the commissioner may suspend, revoke, or limit the license of:
650 (i) the individual;
651 (ii) the navigator agency, if the navigator agency:
652 (A) is reckless or negligent in its supervision of the individual; or
653 (B) knowingly participates in the act or failure to act that is the ground for suspending,
654 revoking, or limiting the license; or
655 (iii) (A) the individual; and
656 (B) the navigator agency, if the agency meets the requirements of Subsection (8)(b)(ii).
657 Section 15. Section **31A-23b-210** is enacted to read:
658 **31A-23b-210. Place of business and residence address -- Records.**
659 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:
660 (i) the address and telephone numbers of the licensee's principal place of business; and
661 (ii) a valid business email address at which the commissioner may contact the licensee.
662 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the
663 individual shall register and maintain with the commissioner the individual's residence address
664 and telephone number.
665 (c) A licensee shall notify the commissioner within 30 days of a change of any of the
666 following required to be registered with the commissioner under this section:
667 (i) an address;
668 (ii) a telephone number; or
669 (iii) a business email address.
670 (2) Except as provided under Subsection (3), a licensee under this chapter shall keep at
671 the principal place of business address registered under Subsection (1), separate and distinct
672 books and records of the transactions consummated under the Utah license.
673 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can

674 be obtained immediately from a central storage place or elsewhere by online computer
675 terminals located at the registered address.
676 (4) (a) The books and records maintained under Subsection (2) shall be available for
677 the inspection by the commissioner during the business hours for a period of time after the date
678 of the transaction as specified by the commissioner by rule, but in no case for less than the
679 current calendar year plus three years.
680 (b) Discarding books and records after the applicable record retention period has
681 expired does not place the licensee in violation of a later-adopted longer record retention
682 period.
683 Section 16. Section **31A-23b-211** is enacted to read:
684 **31A-23b-211. Exceptions to navigator licensing.**
685 (1) For purposes of this section:
686 (a) "Negotiate" is as defined in Section 31A-23a-102.
687 (b) "Sell" is as defined in Section 31A-23a-102.
688 (c) "Solicit" is as defined in Section 31A-23a-102.
689 (2) The commissioner may not require a license as a navigator of:
690 (a) a person who is employed by or contracts with:
691 (i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility
692 Licensing and Inspection Act, to assist an individual with enrollment in a public program or an
693 application for premium subsidy; or
694 (ii) the state, a political subdivision of the state, an entity of a political subdivision of
695 the state, or a public school district to assist an individual with enrollment in a public program
696 or an application for premium subsidy;
697 (b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social
698 Security Act which assists an individual with enrollment in a public program or an application
699 for premium subsidy;
700 (c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants,
701 and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to

702 sell, solicit, or negotiate accident and health insurance plans;
703 (d) an officer, director, or employee of a navigator:
704 (i) who does not receive compensation or commission from an insurer issuing an
705 insurance contract, an agency administering a public program, an individual who enrolled in a
706 public program or insurance product, or an exchange; and
707 (ii) whose activities:
708 (A) are executive, administrative, managerial, clerical, or a combination thereof;
709 (B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the
710 enrollment in a public program offered through the exchange;
711 (C) are in the capacity of a special agent or agency supervisor assisting an insurance
712 producer or navigator;
713 (D) are limited to providing technical advice and assistance to a licensed insurance
714 producer or navigator; or
715 (E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment
716 in a public program; and
717 (e) a person who does not sell, solicit, or negotiate insurance and is not directly or
718 indirectly compensated by an insurer issuing an insurance contract, an agency administering a
719 public program, an individual who enrolled in a public program or insurance product, or an
720 exchange, including:
721 (i) an employer, association, officer, director, employee, or trustee of an employee trust
722 plan who is engaged in the administration or operation of a program:
723 (A) of employee benefits for the employer's or association's own employees or the
724 employees of a subsidiary or affiliate of an employer or association; and
725 (B) that involves the use of insurance issued by an insurer or enrollment in a public
726 health plan on an exchange;
727 (ii) an employee of an insurer or organization employed by an insurer who is engaging
728 in the inspection, rating, or classification of risk, or the supervision of training of insurance
729 producers; or

730 (iii) an employee who counsels or advises the employee's employer with regard to the
731 insurance interests of the employer, or a subsidiary or business affiliate of the employer.
732 (3) The exemption from licensure under Subsections (2)(a) and (b) does not apply if a
733 person described in Subsections (2)(a) and (b) enrolls a person in a private insurance plan.
734 (4) The commissioner may by rule exempt a class of persons from the license
735 requirement of Subsection 31A-23b-201(1) if:
736 (a) the functions performed by the class of persons do not require:
737 (i) special competence;
738 (ii) special trustworthiness; or
739 (iii) regulatory surveillance made possible by licensing; or
740 (b) other existing safeguards make regulation unnecessary.
741 Section 17. Section **31A-23b-301** is enacted to read:
742 **Part 3. Unlawful Conduct and Limitation of Scope of Practice**
743 **31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.**
744 (1) As used in this section, "false or misleading information" includes, with intent to
745 deceive a person examining it:
746 (a) filing a report;
747 (b) making a false entry in a record; or
748 (c) willfully refraining from making a proper entry in a record.
749 (2) (a) Communication that contains false or misleading information relating to
750 enrollment in an insurance plan or a public program, including information that is false or
751 misleading because it is incomplete, may not be made by:
752 (i) a person who is or should be licensed under this title;
753 (ii) an employee of a person described in Subsection (2)(a)(i);
754 (iii) a person whose primary interest is as a competitor of a person licensed under this
755 title; and
756 (iv) a person on behalf of any of the persons listed in this Subsection (2)(a).
757 (b) A licensee under this chapter may not:

758 (i) use any business name, slogan, emblem, or related device that is misleading or
759 likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental
760 agency, a PPACA exchange, insurer, or other licensee already in business; or
761 (ii) use any advertisement or other insurance promotional material that would cause a
762 reasonable person to mistakenly believe that a state or federal government agency, public
763 program, or insurer:
764 (A) is responsible for the insurance or public program enrollment assistance activities
765 of the person;
766 (B) stands behind the credit of the person; or
767 (C) is a source of payment of any insurance obligation of or sold by the person.
768 (c) A person who is not an insurer may not assume or use any name that deceptively
769 implies or suggests that person is an insurer.
770 (3) A person may not engage in an unfair method of competition or any other unfair or
771 deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
772 after a finding that the method of competition, the act, or the practice:
773 (a) is misleading;
774 (b) is deceptive;
775 (c) is unfairly discriminatory;
776 (d) provides an unfair inducement; or
777 (e) unreasonably restrains competition.
778 (4) A navigator licensed under this chapter is subject to the inducement provisions of
779 Section 31A-23a-402.5.
780 (5) A navigator licensed under this chapter or who should be licensed under this
781 chapter:
782 (a) may not receive direct or indirect compensation from an accident or health insurer
783 or from an individual who receives services from a navigator in accordance with:
784 (i) federal conflict of interest regulations established pursuant to PPACA; and
785 (ii) administrative rule adopted by the department;

786 (b) may be compensated by the exchange for performing the duties of a navigator;
787 (c) (i) may perform, offer to perform, or advertise a service as a navigator only for a
788 person selecting a qualified health plan or public program offered on an exchange; and
789 (ii) may not perform, offer to perform, or advertise any services as a navigator for
790 individuals or small employer groups selecting accident and health insurance plans, qualified
791 health plans, public programs, business, or services that are not offered on an exchange; and
792 (d) may not recommend a particular accident and health insurance plan or qualified
793 health plan.
794 Section 18. Section **31A-23b-401** is enacted to read:
795 **Part 4. License Denial and Discipline**
796 **31A-23b-401. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
797 **terminating a license -- Rulemaking for renewal or reinstatement.**
798 (1) A license as a navigator under this chapter remains in force until:
799 (a) revoked or suspended under Subsection (4);
800 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
801 administrative action;
802 (c) the licensee dies or is adjudicated incompetent as defined under:
803 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
804 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
805 Minors;
806 (d) lapsed under this section; or
807 (e) voluntarily surrendered.
808 (2) The following may be reinstated within one year after the day on which the license
809 is no longer in force:
810 (a) a lapsed license; or
811 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
812 not be reinstated after the license period in which the license is voluntarily surrendered.
813 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a

814 license, submission and acceptance of a voluntary surrender of a license does not prevent the
815 department from pursuing additional disciplinary or other action authorized under:
816 (a) this title; or
817 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
818 Administrative Rulemaking Act.
819 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
820 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
821 commissioner may:
822 (i) revoke a license;
823 (ii) suspend a license for a specified period of 12 months or less;
824 (iii) limit a license in whole or in part; or
825 (iv) deny a license application.
826 (b) The commissioner may take an action described in Subsection (4)(a) if the
827 commissioner finds that the licensee:
828 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
829 31A-23b-206;
830 (ii) violated:
831 (A) an insurance statute;
832 (B) a rule that is valid under Subsection 31A-2-201(3); or
833 (C) an order that is valid under Subsection 31A-2-201(4);
834 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
835 delinquency proceedings in any state;
836 (iv) failed to pay a final judgment rendered against the person in this state within 60
837 days after the day on which the judgment became final;
838 (v) refused:
839 (A) to be examined; or
840 (B) to produce its accounts, records, and files for examination;
841 (vi) had an officer who refused to:

842 (A) give information with respect to the navigator's affairs; or
843 (B) perform any other legal obligation as to an examination;
844 (vii) provided information in the license application that is:
845 (A) incorrect;
846 (B) misleading;
847 (C) incomplete; or
848 (D) materially untrue;
849 (viii) violated an insurance law, valid rule, or valid order of another state's insurance
850 department;
851 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
852 (x) improperly withheld, misappropriated, or converted money or properties received
853 in the course of doing insurance business;
854 (xi) intentionally misrepresented the terms of an actual or proposed:
855 (A) insurance contract;
856 (B) application for insurance; or
857 (C) application for public program;
858 (xii) is convicted of a felony;
859 (xiii) admitted or is found to have committed an insurance unfair trade practice or
860 fraud;
861 (xiv) in the conduct of business in this state or elsewhere:
862 (A) used fraudulent, coercive, or dishonest practices; or
863 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
864 (xv) had an insurance license, navigator license, or its equivalent, denied, suspended,
865 or revoked in another state, province, district, or territory;
866 (xvi) forged another's name to:
867 (A) an application for insurance;
868 (B) a document related to an insurance transaction;
869 (C) a document related to an application for a public program; or

870 (D) a document related to an application for premium subsidies;
871 (xvii) improperly used notes or another reference material to complete an examination
872 for a license;
873 (xviii) knowingly accepted insurance business from an individual who is not licensed;
874 (xix) failed to comply with an administrative or court order imposing a child support
875 obligation;
876 (xx) failed to:
877 (A) pay state income tax; or
878 (B) comply with an administrative or court order directing payment of state income
879 tax;
880 (xxi) violated or permitted others to violate the federal Violent Crime Control and Law
881 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
882 prohibited from engaging in the business of insurance; or
883 (xxii) engaged in a method or practice in the conduct of business that endangered the
884 legitimate interests of customers and the public.
885 (c) For purposes of this section, if a license is held by an agency, both the agency itself
886 and any individual designated under the license are considered to be the holders of the license.
887 (d) If an individual designated under the agency license commits an act or fails to
888 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
889 the commissioner may suspend, revoke, or limit the license of:
890 (i) the individual;
891 (ii) the agency, if the agency:
892 (A) is reckless or negligent in its supervision of the individual; or
893 (B) knowingly participates in the act or failure to act that is the ground for suspending,
894 revoking, or limiting the license; or
895 (iii) (A) the individual; and
896 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
897 (5) A licensee under this chapter is subject to the penalties for acting as a licensee

898 without a license if:

899 (a) the licensee's license is:

900 (i) revoked;

901 (ii) suspended;

902 (iii) surrendered in lieu of administrative action;

903 (iv) lapsed; or

904 (v) voluntarily surrendered; and

905 (b) the licensee:

906 (i) continues to act as a licensee; or

907 (ii) violates the terms of the license limitation.

908 (6) A licensee under this chapter shall immediately report to the commissioner:

909 (a) a revocation, suspension, or limitation of the person's license in another state, the

910 District of Columbia, or a territory of the United States;

911 (b) the imposition of a disciplinary sanction imposed on that person by another state,

912 the District of Columbia, or a territory of the United States; or

913 (c) a judgment or injunction entered against that person on the basis of conduct

914 involving:

915 (i) fraud;

916 (ii) deceit;

917 (iii) misrepresentation; or

918 (iv) a violation of an insurance law or rule.

919 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a

920 license in lieu of administrative action may specify a time, not to exceed five years, within

921 which the former licensee may not apply for a new license.

922 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the

923 former licensee may not apply for a new license for five years from the day on which the order

924 or agreement is made without the express approval of the commissioner.

925 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of

926 a license issued under this chapter if so ordered by a court.
927 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
928 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
929 Section 19. Section **31A-23b-402** is enacted to read:
930 **31A-23b-402. Probation -- Grounds for revocation.**
931 (1) The commissioner may place a licensee on probation for a period not to exceed 24
932 months as follows:
933 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
934 Procedures Act, for any circumstances that would justify a suspension under this section; or
935 (b) at the issuance of a new license:
936 (i) with an admitted violation under 18 U.S.C. Secs. 1033 and 1034; or
937 (ii) with a response to background information questions on a new license application
938 indicating that:
939 (A) the person has been convicted of a crime that is listed by rule made in accordance
940 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for
941 probation;
942 (B) the person is currently charged with a crime that is listed by rule made in
943 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
944 a ground for probation regardless of whether adjudication is withheld;
945 (C) the person has been involved in an administrative proceeding regarding any
946 professional or occupational license; or
947 (D) any business in which the person is or was an owner, partner, officer, or director
948 has been involved in an administrative proceeding regarding any professional or occupational
949 license.
950 (2) The commissioner may place a licensee on probation for a specified period no
951 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. Secs. 1033
952 and 1034.
953 (3) The probation order shall state the conditions for revocation or retention of the

954 license, which shall be reasonable.
955 (4) Any violation of the probation is a ground for revocation pursuant to any
956 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.
957 Section 20. Section **31A-23b-403** is enacted to read:
958 **31A-23b-403. License lapse and voluntary surrender.**
959 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:
960 (i) pay when due a fee under Section 31A-3-103;
961 (ii) complete continuing education requirements under Section 31A-23b-206 before
962 submitting the license renewal application;
963 (iii) submit a completed renewal application as required by Section 31A-23b-203;
964 (iv) submit additional documentation required to complete the licensing process; or
965 (v) maintain an active license in a resident state if the licensee is a nonresident
966 licensee.
967 (b) (i) A licensee whose license lapses due to the following may request an action
968 described in Subsection (1)(b)(ii):
969 (A) military service;
970 (B) voluntary service for a period of time designated by the person for whom the
971 licensee provides voluntary service; or
972 (C) other extenuating circumstances, including long-term medical disability.
973 (ii) A licensee described in Subsection (1)(b)(i) may request:
974 (A) reinstatement of the license no later than one year after the day on which the
975 license lapses; and
976 (B) waiver of any of the following imposed for failure to comply with renewal
977 procedures:
978 (I) an examination requirement;
979 (II) reinstatement fees set under Section 31A-3-103;
980 (III) continuing education requirements; or
981 (IV) other sanctions imposed for failure to comply with renewal procedures.

982 (2) If a license issued under this chapter is voluntarily surrendered, the license may be
983 reinstated:
984 (a) during the license period in which the license is voluntarily surrendered; and
985 (b) no later than one year after the day on which the license is voluntarily surrendered.
986 (3) A voluntarily surrendered license that is reinstated during the license period set
987 forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the
988 license complies with any applicable continuing education requirements for the period during
989 which the license was voluntarily surrendered.
990 Section 21. Section **31A-23b-404** is enacted to read:
991 **31A-23b-404. Penalties.**
992 (1) (a) If, after notice and opportunity to be heard, the commissioner finds that the
993 navigator or any other person has not materially complied with this part, or any rule made or
994 order issued under this chapter, the commissioner may order the navigator or other person to
995 cease doing business in the state.
996 (b) If the commissioner finds that because of the material noncompliance an insurer,
997 any policyholder of an insurer, or a recipient of a public program who used the services of the
998 navigator or other person has suffered any loss or damage due to the material noncompliance,
999 the commissioner may:
1000 (i) maintain a civil action or may intervene in an action brought by or on behalf of the
1001 insurer, policyholder, or the recipient of the public program, for recovery of compensatory
1002 damages for the benefit of the insurer, policyholder, or recipient of a public program; or
1003 (ii) seek other appropriate relief.
1004 (2) Nothing in this section affects the right of the commissioner to impose any other
1005 penalties provided for in this title.
1006 (3) Nothing contained in this section is intended to or shall in any manner alter or
1007 affect the rights of policyholders, claimants, creditors, or other third parties.
1008 Section 22. Section **31A-30-104** is amended to read:
1009 **31A-30-104. Applicability and scope.**

1010 (1) This chapter applies to any:
1011 (a) health benefit plan that provides coverage to:
1012 (i) individuals;
1013 (ii) small employers; or
1014 (iii) both Subsections (1)(a)(i) and (ii); or
1015 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
1016 31A-30-107.5.
1017 (2) This chapter applies to a health benefit plan that provides coverage to small
1018 employers or individuals regardless of:
1019 (a) whether the contract is issued to:
1020 (i) an association;
1021 (ii) a trust;
1022 (iii) a discretionary group; or
1023 (iv) other similar grouping; or
1024 (b) the situs of delivery of the policy or contract.
1025 (3) This chapter does not apply to:
1026 (a) short-term limited duration health insurance; or
1027 (b) federally funded or partially funded programs.
1028 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:
1029 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
1030 return shall be treated as one carrier; and
1031 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
1032 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
1033 carriers were issued by one carrier.
1034 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
1035 maintenance organization having a certificate of authority under this title may be considered to
1036 be a separate carrier for the purposes of this chapter.
1037 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined

1038 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
1039 arrangements with respect to health benefit plans delivered or issued for delivery to covered
1040 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
1041 obligation or risk for the health benefit plans being retained by the ceding carrier.
1042 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
1043 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
1044 for delivery to covered insureds in this state.
1045 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
1046 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
1047 may make a written request to the commissioner for a waiver from the application of any of the
1048 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
1049 trust.
1050 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
1051 waiver if the commissioner finds that application with respect to the trust would:
1052 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
1053 and
1054 (ii) require significant modifications to one or more collective bargaining arrangements
1055 under which the trust is established or maintained.
1056 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
1057 person participates in a Taft Hartley trust as an associate member of any employee
1058 organization.
1059 (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
1060 31A-30-111 apply to:
1061 (a) any insurer engaging in the business of insurance related to the risk of a small
1062 employer for medical, surgical, hospital, or ancillary health care expenses of the small
1063 employer's employees provided as an employee benefit; and
1064 (b) any contract of an insurer, other than a workers' compensation policy, related to the
1065 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the

1066 small employer's employees provided as an employee benefit.

1067 (7) The commissioner may make rules requiring that the marketing practices be
1068 consistent with this chapter for:

1069 (a) a small employer carrier;

1070 (b) a small employer carrier's agent;

1071 (c) an insurance producer; [~~and~~]

1072 (d) an insurance consultant; and

1073 (e) a navigator.

1074 Section 23. Section **31A-30-105** is amended to read:

1075 **31A-30-105. Establishment of classes of business.**

1076 [~~(1) For a policy that takes effect on or after January 1, 2011~~] Effective January 1,
1077 2014, a covered carrier may [~~not~~] establish [~~a separate class~~] up to four separate classes of
1078 business [~~unless~~]:

1079 [~~(a) the covered carrier submits an application to the commissioner to establish a~~
1080 ~~separate class of business;~~]

1081 [~~(b) the covered carrier demonstrates to the satisfaction of the commissioner that a~~
1082 ~~separate class of business is justified under the provisions of this section; and~~]

1083 [~~(c) the commissioner approves the carrier's application for the use of a separate class~~
1084 ~~of business.~~]

1085 [~~(2) (a) The commissioner shall have a presumption against the use of a separate class~~
1086 ~~of business by a covered insured, except when the covered carrier demonstrates that this~~
1087 ~~Subsection (2) applies.~~]

1088 [~~(b) The commissioner may approve the use of a separate class of business only if the~~
1089 ~~covered carrier can demonstrate that the use of a separate class of business is necessary due to~~
1090 ~~substantial differences in either expected claims experience or administrative costs related to~~
1091 ~~the following reasons:~~]

1092 [~~(i) the covered carrier uses more than one type of system for the marketing and sale of~~
1093 ~~health benefit plans to covered insureds;~~]

1094 [~~(ii) the covered carrier has acquired a class of business from another covered carrier;~~
1095 ~~or~~]
1096 [~~(iii) the covered carrier provides coverage to one or more association groups.~~]
1097 [~~(3) The commissioner may establish regulations to provide for a period of transition in~~
1098 ~~order for a covered carrier to come into compliance with Subsection (2) in the instance of~~
1099 ~~acquisition of an additional class of business from another covered carrier.~~]
1100 [~~(4) The commissioner may approve the establishment of up to five classes of business~~
1101 ~~per covered carrier upon application to the commissioner and a finding by the commissioner~~
1102 ~~that such action would substantially enhance the efficiency and fairness of the health insurance~~
1103 ~~marketplace subject to this chapter.~~]
1104 [~~(5) A covered carrier may not establish a class of business based solely on the~~
1105 ~~marketing or sale of a health benefit plan as a defined contribution arrangement health benefit~~
1106 ~~plan, or through the Health Insurance Exchange.~~]
1107 (1) one class of business for individual health benefit plans that are not grandfathered
1108 under PPACA;
1109 (2) one class of business for small employer health benefit plans that are not
1110 grandfathered under PPACA;
1111 (3) one class of business for individual health benefit plans that are grandfathered
1112 under PPACA; and
1113 (4) one class of business for small employer health benefit plans that are grandfathered
1114 under PPACA.
1115 Section 24. Section **31A-30-107.3** is amended to read:
1116 **31A-30-107.3. Discontinuance and nonrenewal limitations and conditions.**
1117 (1) [~~(a)~~] A carrier that elects to discontinue offering [~~a~~] all individual health benefit
1118 [~~plan~~] plans under Subsection [~~31A-30-107(3)(e) or~~] 31A-30-107.1(3)(e) is prohibited from
1119 writing new business[~~:(i) in the small employer and~~] in the individual market in this state[~~; and~~
1120 ~~(ii)~~] for a period of five years beginning on the date of discontinuation of the last individual
1121 health benefit plan coverage that is discontinued.

1122 [(b) The prohibition described in Subsection (1)(a) may be waived if the commissioner
1123 finds that waiver is in the public interest:]
1124 [(i) to promote competition; or]
1125 [(ii) to resolve inequity in the marketplace.]
1126 (2) A carrier that elects to discontinue offering all small employer health benefit plans
1127 under Subsection 31A-30-107(3)(e) is prohibited from writing new business in the small group
1128 market in this state for a period of five years beginning on the date of discontinuation of the
1129 last small employer coverage that is discontinued.
1130 [(2)] (3) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A,
1131 Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if
1132 enrollment is capped or suspended, an individual carrier:
1133 (i) may, except as prohibited by Section 31A-30-117, elect to discontinue offering new
1134 individual health benefit plans, except to HIPAA eligibles, but shall keep existing individual
1135 health benefit plans in effect, except those individual plans that are not renewed under the
1136 provisions of Subsection 31A-30-107(2) or 31A-30-107.1(2);
1137 (ii) may elect to continue to offer new individual and small employer health benefit
1138 plans; or
1139 (iii) may elect to discontinue all of the covered carrier's health benefit plans in the
1140 individual or small group market under the provisions of Subsection 31A-30-107(3)(e) or
1141 31A-30-107.1(3)(e).
1142 (b) A carrier that makes an election under Subsection [(2)] (3)(a)(i):
1143 (i) is prohibited from writing new business:
1144 (A) in the individual market in this state; and
1145 (B) for a period of five years beginning on the date of discontinuation;
1146 (ii) may continue to write new business in the small employer market; and
1147 (iii) shall provide written notice of the election under Subsection [(2)] (3)(a)(i) within
1148 two calendar days of the election to the Utah Insurance Department.
1149 (c) The prohibition described in Subsection [(2)] (3)(b)(i) may be waived if the

1150 commissioner finds that waiver is in the public interest:

1151 (i) to promote competition; or

1152 (ii) to resolve inequity in the marketplace.

1153 (d) A carrier that makes an election under Subsection [(2)] (3)(a)(iii) is subject to the

1154 provisions of Subsection (1).

1155 [(3)] (4) If a carrier is doing business in one established geographic service area of the

1156 state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that

1157 geographic service area.

1158 [(4)] (5) If a small employer employs less than two eligible employees, a carrier may

1159 not discontinue or not renew the health benefit plan until the first renewal date following the

1160 beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that

1161 the employer no longer has at least two current employees.

1162 Section 25. Section **31A-30-112** is amended to read:

1163 **31A-30-112. Employee participation levels.**

1164 (1) (a) For purposes of this section, "participation" is as defined in Section 31A-1-301.

1165 [(1) (a)] (b) Except as provided in Subsection (2) and Section 31A-30-206, a

1166 requirement used by a covered carrier in determining whether to provide coverage to a small

1167 employer, including a participation requirement [for minimum participation of eligible

1168 employees] and a minimum employer [contributions] contribution requirement, shall be

1169 applied uniformly among all small employers with the same number of eligible employees

1170 applying for coverage or receiving coverage from the covered carrier.

1171 [(b) In addition to applying Subsection 31A-1-301(124), a covered carrier may require

1172 that a small employer have a minimum of two eligible employees to meet participation

1173 requirements.]

1174 (2) A covered carrier may not increase a [requirement for minimum employee]

1175 participation requirement or a requirement for minimum employer contribution, applicable to a

1176 small employer, at any time after the small employer is accepted for coverage.

1177 Section 26. Section **31A-30-115** is amended to read:

1178 **31A-30-115. Actuarial review of health benefit plans.**
1179 (1) (a) The department shall conduct an actuarial review of rates submitted by [~~small~~
1180 ~~employer carriers~~] a carrier that offers a small employer plan and a carrier that offers an
1181 individual plan under this chapter:
1182 [~~(i) prior to the publication of the premium rates on the Health Insurance Exchange;~~]
1183 [~~(ii) except as permitted by Subsection 31A-30-207(2), to determine if the carrier is~~
1184 ~~using the same rating and underwriting practices in both the defined contribution arrangement~~
1185 ~~market in the Health Insurance Exchange and the defined benefit market offered outside the~~
1186 ~~Health Insurance Exchange, in compliance with Subsection 31A-30-202.5(1)(b);~~]
1187 [~~(iii) to verify the validity of the rates, underwriting and risk factors, and premiums of~~
1188 ~~plans both in and outside of the Health Insurance Exchange;~~]
1189 [~~(iv) to verify that insurers are pricing similar health benefit plans and groups the same~~
1190 ~~in and out of the exchange, except as permitted by Subsection 31A-30-207(2); and~~]
1191 (i) to verify the valildity of the rates, risk factors, and premiums of the plans; and
1192 [~~(v)~~] (ii) as the department determines is necessary to oversee market conduct.
1193 (b) The actuarial review by the department shall be funded from a fee:
1194 (i) established by the department in accordance with Section 63J-1-504; and
1195 (ii) paid by [~~all small employer carriers participating in the defined contribution~~
1196 ~~arrangement market and small employer carriers offering health benefit plans under Part 1,~~
1197 ~~Individual and Small Employer Group~~] a carrier offering a health benefit plan subject to this
1198 chapter.
1199 (c) The department shall:
1200 (i) report aggregate data from the actuarial review to the risk adjuster board created in
1201 Section 31A-42-201; and
1202 (ii) contact carriers, if the department determines it is appropriate, to:
1203 (A) inform a carrier of the department's findings regarding the rates of a particular
1204 carrier; and
1205 (B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

1206 (d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).
1207 (2) (a) There is created in the General Fund a restricted account known as the "Health
1208 Insurance Actuarial Review Restricted Account."
1209 (b) The Health Insurance Actuarial Review Restricted Account shall consist of money
1210 received by the commissioner under this section.
1211 (c) The commissioner shall administer the Health Insurance Actuarial Review
1212 Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use
1213 money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the
1214 actuarial review conducted by the department under this section.
1215 Section 27. Section **31A-30-117** is enacted to read:
1216 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**
1217 (1) (a) After complying with the reporting requirements of Section 63M-1-2505.5, the
1218 commissioner may adopt administrative rules that change the rating and underwriting
1219 requirements of this chapter as necessary to transition the insurance market to meet federal
1220 qualified health plan standards and rating practices under PPACA.
1221 (b) Administrative rules adopted by the commissioner under this section may include:
1222 (i) the regulation of health benefit plans as described in Subsections 31A-2-212(5)(a)
1223 and (b); and
1224 (ii) disclosure of records and information required by PPACA and state law.
1225 (c) (i) The commissioner shall establish by administrative rule one statewide open
1226 enrollment period that applies to the individual insurance market that is not on the PPACA
1227 certified individual exchange.
1228 (ii) The statewide open enrollment period:
1229 (A) may be shorter, but no longer than the open enrollment period established for the
1230 individual insurance market offered in the PPACA certified exchange; and
1231 (B) may not be extended beyond the dates of the open enrollment period established
1232 for the individual insurance market offered in the PPACA certified exchange.
1233 (2) A carrier that offers health benefit plans in the individual market that is not part of

1234 the individual PPACA certified exchange:
1235 (a) shall open enrollment:
1236 (i) during the statewide open enrollment period established in Subsection (1)(c); and
1237 (ii) at other times, for qualifying events, as determined by administrative rule adopted
1238 by the commissioner; and
1239 (b) may open enrollment at any time.
1240 (3) (a) The commissioner shall identify a new mandated benefit that is in excess of the
1241 essential health benefits required by PPACA.
1242 (b) In accordance with 45 C.F.R. Sec. 155.170, the state shall make a payment to
1243 defray the cost of a new mandated benefit in the amount calculated under Subsection (3)(c)
1244 directly to the qualified health plan issuer on behalf of an individual who receives an advance
1245 premium tax credit under PPACA.
1246 (c) The state shall quantify the cost attributable to each additional mandated benefit
1247 specified in Subsection (3)(a) based on a qualified health plan issuer's calculation of the cost
1248 associated with the mandated benefit, which shall be:
1249 (i) calculated in accordance with generally accepted actuarial principles and
1250 methodologies;
1251 (ii) conducted by a member of the American Academy of Actuaries; and
1252 (iii) reported to the commissioner and to the individual exchange operating in the state.
1253 (d) The commissioner may require a proponent of a new mandated benefit under
1254 Subsection (3)(a) to provide the commissioner with a cost analysis conducted in accordance
1255 with Subsection (3)(c). The commissioner may use the cost information provided under this
1256 Subsection (3)(d) to establish estimates of the cost to the state for premium subsidies under
1257 Subsection (3)(b).
1258 Section 28. Section **31A-30-202.6** is enacted to read:
1259 **31A-30-202.6. Dental and vision plans on the defined contribution arrangement**
1260 **market.**
1261 (1) Beginning January 1, 2014, a carrier may offer dental and vision plans in the

1262 defined contribution arrangement market.

1263 (2) (a) A carrier that offers a dental or vision plan in the defined contribution

1264 arrangement market is not required to offer the same dental or vision plans outside the defined

1265 contribution arrangement market and does not have to use the same rating and underwriting

1266 practices in and out of the defined contribution arrangement market.

1267 (b) If a carrier offers a dental or vision plan in the defined contribution arrangement

1268 market, the carrier shall allow an employee of a small employer group to enroll in a dental and

1269 vision plan in accordance with Subsection (3).

1270 (3) (a) A small employer group shall participate in a defined contribution arrangement

1271 and meet participation requirements for the defined contribution arrangement before the

1272 employer may elect to offer its employees dental or vision plans under Subsection (3)(b).

1273 (b) A small employer who meets the requirements of Subsection (3)(a) may elect to

1274 offer its employees:

1275 (i) a dental plan offered in the defined contribution arrangement market;

1276 (ii) a vision plan offered in the defined contribution arrangement market; or

1277 (iii) both a vision plan and a dental plan offered in the defined contribution

1278 arrangement market.

1279 (4) An employee whose employer has offered its employees a defined contribution

1280 medical plan and met participation requirements under Subsection (3)(a) may elect to enroll, or

1281 not enroll, in the dental and vision plan selected by the employer.

1282 (5) An employer's small group must meet participation requirements established by the

1283 commissioner by administrative rule for each dental or vision plan selected by an employer

1284 under Subsection (3).

1285 Section 29. Section **31A-30-208** is amended to read:

1286 **31A-30-208. Enrollment for defined contribution arrangements.**

1287 (1) An insurer offering a health benefit plan in the defined contribution arrangement

1288 market:

1289 (a) shall allow an employer to enroll in a small employer defined contribution

1290 arrangement plan; and

1291 [~~(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer~~

1292 ~~group selecting a defined contribution arrangement health benefit plan on or before January 1,~~

1293 ~~2012; and~~]

1294 [~~(c)~~] (b) shall otherwise comply with the requirements of this part, Chapter 42, Defined

1295 Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

1296 (2) (a) [~~Except as provided in Subsection 31A-30-202.5(2), in accordance with~~

1297 ~~Subsection (2)(b), on January 1 of each year, an~~] An insurer may enter or exit the defined

1298 contribution arrangement market on January 1 of each year.

1299 (b) An insurer may offer new or modify existing products in the defined contribution

1300 arrangement market:

1301 (i) on January 1 of each year;

1302 (ii) when required by changes in other law; and

1303 (iii) at other times as established by the risk adjuster board created in Section

1304 31A-42-201.

1305 (c) [~~(i)~~] An insurer shall give the department, the Health Insurance Exchange, and the

1306 risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a)

1307 or (b).

1308 [~~(ii) When an insurer elects to participate in the defined contribution arrangement~~

1309 ~~market, the insurer shall participate in the defined contribution arrangement market for no less~~

1310 ~~than two years.~~]

1311 Section 30. Section **31A-43-101** is enacted to read:

1312 **CHAPTER 43. SMALL EMPLOYER STOP-LOSS INSURANCE ACT**

1313 **Part 1. General Provisions**

1314 **31A-43-101. Title.**

1315 This chapter is known as the "Small Employer Stop-Loss Insurance Act."

1316 Section 31. Section **31A-43-102** is enacted to read:

1317 **31A-43-102. Definitions.**

1318 For purposes of this chapter:
1319 (1) "Actuarial certification" means a written statement by a member of the American
1320 Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer
1321 is in compliance with the provisions of this chapter, based upon the individual's examination
1322 and including a review of the appropriate records and the actuarial assumptions and methods
1323 used by the stop-loss insurer in establishing attachment points and other applicable
1324 determinations in conjunction with the provision of stop-loss insurance coverage.
1325 (2) "Aggregate attachment point" means the dollar amount in losses for eligible
1326 expenses incurred by a small employer plan beyond which the stop-loss insurer incurs liability
1327 for all or part of the losses incurred by the small employer plan, subject to limitations included
1328 in the contract.
1329 (3) "Coverage" means the combination of the employer plan design and the stop-loss
1330 contract design.
1331 (4) "Expected claims" means the amount of claims that, in the absence of a stop-loss
1332 contract, are projected to be incurred by a small employer health plan using reasonable and
1333 accepted actuarial principles.
1334 (5) "Lasering":
1335 (a) means increasing or removing stop-loss coverage for a specific individual within an
1336 employer group; and
1337 (b) includes other practices that are prohibited by the commissioner by administrative
1338 rule that result in lowering the stop-loss premium for the employer by transferring the risk for
1339 an individual.
1340 (6) "Small employer" means an employer who, with respect to a calendar year and to a
1341 plan year:
1342 (a) employed an average of at least two employees but not more than 50 eligible
1343 employees on each business day during the preceding calendar year; and
1344 (b) employs at least two employees on the first day of the plan year.
1345 (7) "Specific attachment point" means the dollar amount in losses for eligible expenses

1346 attributable to a single individual covered by a small employer plan in a contract year beyond
1347 which the stop-loss insurer assumes all or part of the liability for losses incurred by the small
1348 employer plan, subject to limitations included in the contract.
1349 (8) "Stop-loss insurance" means insurance purchased by a small employer for which
1350 the stop-loss insurer assumes, on a per-loss basis, all loss amounts of the small employer's plan
1351 in excess of a stated amount, subject to the policy limit.
1352 Section 32. Section **31A-43-201** is enacted to read:
1353 **Part 2. Scope of Chapter**
1354 **31A-43-201. Scope of chapter.**
1355 (1) This chapter establishes criteria for the issuance of stop-loss insurance contracts or
1356 re-insurance contracts for small employers that establish self-funded or partially self-funded
1357 health plans for the small employer's employees. This chapter does not:
1358 (a) impose any requirement or duty on any person other than a stop-loss insurer or
1359 re-insurer who issues a stop-loss insurance contract to a small employer;
1360 (b) treat any stop-loss insurance contract as a direct policy of health insurance; or
1361 (c) constitute an attempt to exercise authority over self-funded or partially self-funded
1362 health benefit plans sponsored by a small employer.
1363 (2) This chapter applies to a small employer stop-loss contract issued or renewed on or
1364 after July 1, 2013.
1365 Section 33. Section **31A-43-202** is enacted to read:
1366 **31A-43-202. Laws applicable to stop-loss insurance.**
1367 A stop-loss insurance contract or a re-insurance contract issued to a small employer that
1368 establishes a self-funded or partially self-funded health plan:
1369 (1) is not reinsurance under this title, and is not subject to the regulations for
1370 reinsurance under this title;
1371 (2) is subject to regulation as stop-loss insurance under this chapter; and
1372 (3) is subject to the contract provisions of this title in the same manner as insurance
1373 contracts issued by any other insurer.

1374 Section 34. Section **31A-43-301** is enacted to read:

1375 **Part 3. Stop-loss Insurance**

1376 **31A-43-301. Stop-loss insurance coverage standards.**

1377 (1) A small employer stop-loss insurance contract shall:

1378 (a) be issued to the small employer to provide insurance to the group health benefit

1379 plan, not the employees of the small employer;

1380 (b) use a standard application form developed by the commissioner by administrative

1381 rule;

1382 (c) have a contract term with guaranteed rates for at least 12 months, without

1383 adjustment, unless there is a change in the benefits provided under the small employer's health

1384 plan during the contract period;

1385 (d) include both a specific attachment point and an aggregate attachment point in a

1386 contract;

1387 (e) align stop-loss plan benefit limitations and exclusions with a small employer's

1388 health plan benefit limitations and exclusions, including any annual or lifetime limits in the

1389 employer's health plan;

1390 (f) have an annual specific attachment point that is at least $10,000;

1391 (g) have an annual aggregate attachment point that may not be less than 90% of

1392 expected claims;

1393 (h) pay stop-loss claims:

1394 (i) incurred during the contract period; and

1395 (ii) submitted within 12 months after the expiration date of the contract; and

1396 (i) include provisions to cover incurred and unpaid claims if a small employer plan

1397 terminates.

1398 (2) A small employer stop-loss contract shall not:

1399 (a) include lasering; and

1400 (b) pay claims directly to an individual employee, member, or participant.

1401 Section 35. Section **31A-43-302** is enacted to read:

1402 **31A-43-302. Stop-loss restrictions -- Filing requirements.**

1403 (1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated
1404 with specific and aggregate attachment points retained by a small employer group under the
1405 insurer's stop-loss plan are actuarially sound.

1406 (2) A stop-loss insurer shall file the stop-loss insurance contract form and rates with
1407 the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1 before the stop-loss
1408 insurance contract may be issued or delivered in the state.

1409 (3) A stop-loss insurer shall file with the commissioner, annually on or before April 1,
1410 in a form and manner required by the commissioner by administrative rule adopted by the
1411 commissioner:

1412 (a) an actuarial memorandum and certification which demonstrates that the insurer is in
1413 compliance with this chapter; and

1414 (b) the stop-loss insurer's stop-loss experience.

1415 (4) Each insurer shall maintain at its principal place of business:

1416 (a) a complete and detailed description of its rating practices and renewal underwriting
1417 practices, including information and documentation that demonstrate the rating methods and
1418 practices are:

1419 (i) based upon commonly accepted actuarial assumptions; and

1420 (ii) in accordance with sound actuarial principles; and

1421 (b) a copy of the actuarial certification required by Subsection (3).

1422 Section 36. Section **31A-43-303** is enacted to read:

1423 **31A-43-303. Stop-loss insurance disclosure.**

1424 A stop-loss insurance contract delivered, issued for delivery, or entered into shall
1425 include the disclosure exhibit required by the commissioner through administrative rule, which
1426 shall include at least the following information:

1427 (1) the complete costs for the stop-loss contract;

1428 (2) the date on which the insurance takes effect and terminates, including renewability
1429 provisions;

1430 (3) the aggregate attachment point and the specific attachment point;
1431 (4) any limitations on coverage;
1432 (5) an explanation of monthly accommodation and disclosure about any monthly
1433 accommodation features included in the stop-loss contract; and
1434 (6) a description of terminal liability funding, including:
1435 (a) cost of processing claims before and after the termination of the contract; and
1436 (b) maximum claims liability to the employer.
1437 Section 37. Section **31A-43-304** is enacted to read:
1438 **31A-43-304. Administrative rules.**
1439 The commissioner may adopt administrative rules in accordance with Title 63G,
1440 Chapter 3, Utah Administrative Rulemaking Act, to:
1441 (1) implement this chapter;
1442 (2) assure that differences in rates charged are reasonable and reflect objective
1443 differences in plan design;
1444 (3) define lasering practices that are prohibited by this chapter;
1445 (4) establish the form and manner of the actuarial certification and the annual report on
1446 stop-loss experience required by Section 31A-43-302;
1447 (5) establish the form and manner of the disclosure required by Section 31A-43-303;
1448 (6) assure the rates associated with the specific attachment points and aggregate
1449 attachment points are actuarially sound and are not against the public interest; and
1450 (7) assure that stop-loss contracts include provisions to cover incurred and unpaid
1451 claims if a small employer plan terminates.
1452 Section 38. Section **63I-2-231 (Superseded 07/01/13)** is amended to read:
1453 **63I-2-231 (Superseded 07/01/13). Repeal dates, Title 31A.**
1454 Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed July 1,
1455 [~~2013~~] 2015.
1456 Section 39. Section **63I-2-231 (Effective 07/01/13)** is amended to read:
1457 **63I-2-231 (Effective 07/01/13). Repeal dates, Title 31A.**

1458 (1) Section 31A-22-315.5 is repealed July 1, 2016.
1459 (2) Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed July 1,
1460 [<s>2013</s>] <u>2015</u>.
1461 Section 40. Section **63M-1-2505.5** is amended to read:
1462 **63M-1-2505.5. Reporting on federal health reform -- Prohibition of individual**
1463 **mandate.**
1464 (1) The Legislature finds that:
1465 (a) the state has embarked on a rigorous process of implementing a strategic plan for
1466 health system reform pursuant to Section 63M-1-2505;
1467 (b) the health system reform efforts for the state were developed to address the unique
1468 circumstances within Utah and to provide solutions that work for Utah;
1469 (c) Utah is a leader in the nation for health system reform which includes:
1470 (i) developing and using health data to control costs and quality; and
1471 (ii) creating a defined contribution insurance market to increase options for employers
1472 and employees; and
1473 (d) the federal government proposals for health system reform:
1474 (i) infringe on state powers;
1475 (ii) impose a uniform solution to a problem that requires different responses in
1476 different states;
1477 (iii) threaten the progress Utah has made towards health system reform; and
1478 (iv) infringe on the rights of citizens of this state to provide for their own health care
1479 by:
1480 (A) requiring a person to enroll in a third party payment system;
1481 (B) imposing fines<u>, penalties, and taxes</u> on a person who chooses to pay directly for
1482 health care rather than use a third party payer;
1483 (C) imposing fines<u>, penalties, and taxes</u> on an employer that does not meet federal
1484 standards for providing health care benefits for employees; and
1485 (D) threatening private health care systems with competing government supported

1486 health care systems.

1487 (2) (a) For purposes of this section:

1488 (i) "Implementation" includes adopting or changing an administrative rule, applying for

1489 or spending federal grant money, issuing a request for proposal to carry out a requirement of

1490 PPACA, entering into a memorandum of understanding with the federal government regarding

1491 a provision of PPACA, or amending the state Medicaid plan.

1492 (ii) "PPACA" is as defined in Section 31A-1-301.

1493 [(2) (a)] (b) A department or agency of the state may not implement any part of [federal

1494 health care reform, as defined in Subsection (3), that is passed by the United States Congress

1495 after March 1, 2010,] PPACA unless, prior to implementation, the department or agency

1496 reports in writing, and, if practicable, in person if requested, to the Legislature's Business and

1497 Labor Interim Committee [and if authorized], the Health Reform Task Force, [and] or the

1498 legislative Executive Appropriations Committee in accordance with Subsection (2)[(c)](d).

1499 [(b)] (c) The Legislature may pass legislation specifically authorizing or prohibiting the

1500 state's compliance with, or participation in[, federal health care reform] provisions of PPACA.

1501 [(c)] (d) The report required under Subsection (2)[(a)](b) shall include:

1502 (i) the specific federal statute or regulation that requires the state to implement a

1503 [federal reform] provision of PPACA;

1504 (ii) whether [the reform provision] PPACA has any state waiver or options;

1505 (iii) exactly what [the reform provision] PPACA requires the state to do, and how it

1506 would be implemented;

1507 (iv) who in the state will be impacted by adopting the federal reform provision, or not

1508 adopting the federal reform provision;

1509 (v) what is the cost to the state or citizens of the state to implement the federal reform

1510 provision; [and]

1511 (vi) the consequences to the state if the state does not comply with [the federal reform

1512 provision.] PPACA;

1513 [(3) For purposes of this section, "federal health care reform" means federal legislation

1514 or federal regulation that:]
1515 [(a) mandates an individual to purchase health insurance;]
1516 [(b) mandates a small employer to provide health insurance coverage for employees;]
1517 [(c) imposes penalties on small employers who do not provide health insurance for
1518 their employees;]
1519 [(d) expands the eligibility for the Medicaid program or the Children's Health
1520 Insurance Program, and passes the cost of that expansion to the state;]
1521 [(e) creates new insurance coverage mandates; or]
1522 [(f) creates a new government run, public insurance program.]
1523 (vii) the impact, if any, of the PPACA requirements regarding:
1524 (A) the state's protection of a health care provider's refusal to perform an abortion on
1525 religious or moral grounds as provided in Section 76-7-306; and
1526 (B) abortion insurance coverage restrictions provided in Section 31A-22-726.
1527 [(4)] (3) (a) [An individual in this state may not be required] The state shall not require
1528 an individual in the state to obtain or maintain health insurance as defined in [Section
1529 31A-1-301] PPACA, regardless of whether the individual has or is eligible for health insurance
1530 coverage under any policy or program provided by or through the individual's employer or a
1531 plan sponsored by the state or federal government.
1532 (b) The provisions of this title may not be used to facilitate the federal PPACA
1533 individual mandate or to hold an individual in this state liable for any penalty, assessment, fee,
1534 or fine as a result of the individual's failure to procure or obtain health insurance coverage.
1535 (c) This section does not apply to an individual who voluntarily applies for coverage
1536 under a state administered program pursuant to Title XIX or Title XXI of the Social Security
1537 Act.
1538 Section 41. **Health Reform Task Force -- Creation -- Membership -- Interim rules**
1539 **followed -- Compensation -- Staff.**
1540 (1) There is created the Health Reform Task Force consisting of the following 11
1541 members:

1542 (a) four members of the Senate appointed by the president of the Senate, no more than
1543 three of whom may be from the same political party; and
1544 (b) seven members of the House of Representatives appointed by the speaker of the
1545 House of Representatives, no more than five of whom may be from the same political party.
1546 (2) (a) The president of the Senate shall designate a member of the Senate appointed
1547 under Subsection (1)(a) as a cochair of the task force.
1548 (b) The speaker of the House of Representatives shall designate a member of the House
1549 of Representatives appointed under Subsection (1)(b) as a cochair of the task force.
1550 (3) In conducting its business, the task force shall comply with the rules of legislative
1551 interim committees.
1552 (4) Salaries and expenses of the members of the task force shall be paid in accordance
1553 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Expense and Mileage
1554 Reimbursement for Authorized Legislative Meetings, Special Sessions, and Veto Override
1555 Sessions.
1556 (5) The Office of Legislative Research and General Counsel shall provide staff support
1557 to the task force.
1558 Section 42. **Duties -- Interim report.**
1559 (1) The task force shall review and make recommendations on the following issues:
1560 (a) the impact of implementation of the federal health reform law and federal
1561 regulations on the state;
1562 (b) options for the state regarding Medicaid expansion and reform;
1563 (c) health care cost containment strategies;
1564 (d) the role of the state defined contribution arrangement market and online health
1565 insurance market places established under PPACA;
1566 (e) governing structure for the state's defined contribution arrangement market;
1567 (f) Medicaid behavioral health delivery and payment reform models within Medicaid
1568 accountable care organizations and other county provided delivery settings, including:
1569 (i) the development of a system to encourage, track, evaluate, share, and disseminate

1570 results from existing pilot projects; and
1571 (ii) payment reform models that promote performance based reimbursement;
1572 (g) the delivery of charity care in the state, including:
1573 (i) the identification of:
1574 (A) medically underserved and needy populations and geographic areas of the state;
1575 (B) barriers in the current health care delivery and payment models to the promotion of
1576 a comprehensive charity care system; and
1577 (C) current resources available for medical care for medically under-served populations
1578 and medically underserved geographic areas in the state; and
1579 (ii) proposals to establish:
1580 (A) wellness education;
1581 (B) personal responsibility for health care; and
1582 (C) a coordinated, statewide, private sector approach to universal, basic health care for
1583 Utah's medically underserved populations and geographic areas, using private partners to affect
1584 cost savings and market efficiencies; and
1585 (h) the use of self-insured health plans by small employers and the regulation of small
1586 employer stop-loss insurance in the state.
1587 (2) A final report, including any proposed legislation, shall be presented to the
1588 Business and Labor Interim Committee before November 30, 2013, and before November 30,
1589 2014.
1590 Section 43. **Appropriation.**
1591 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for
1592 the fiscal year beginning July 1, 2013, and ending June 30, 2014, the following sums of money
1593 are appropriated from resources not otherwise appropriated, or reduced from amounts
1594 previously appropriated, out of the funds or accounts indicated. These sums of money are in
1595 addition to any amounts previously appropriated for fiscal year 2014.
1596 To Legislature - Senate
1597 From General Fund, One-time $30,000

1598 Schedule of Programs:
1599 Administration $30,000
1600 To Legislature - House of Representatives $52,000
1601 From General Fund, One-time
1602 Schedule of Programs:
1603 Administration $52,000
1604 Section 44. **Effective date.**
1605 (1) Except as provided in Subsection (2), if approved by two-thirds of all the members
1606 elected to each house, this bill takes effect upon approval by the governor, or the day following
1607 the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's
1608 signature, or in the case of a veto, the date of veto override.
1609 (2) The actions affecting Section 63I-2-231 (Effective 07/01/13) take effect on July 1,
1610 2013.
1611 Section 45. **Repeal date.**
1612 The Health Reform Task Force is repealed December 30, 2015.