

**Katy Hall** proposes the following substitute bill:

**Health Care Transparency Amendments**

2026 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Katy Hall**

Senate Sponsor:

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**LONG TITLE**

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**General Description:**

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This bill addresses transparency in the Medicaid program.

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**Highlighted Provisions:**

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This bill:

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▸ requires the Division of Integrated Healthcare (division) to maintain a dashboard of certain Medicaid data;

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▸ requires the division to publish certain data and reports on the division's website;

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▸ requires certain participants in the Medicaid program to:

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• identify, report on, and repay improper payments; and

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• develop corrective action plans to address improper payments;

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▸ requires the Department of Health and Human Services (department) to publish reports of improper payments and corrective action plans on the department's website;

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▸ provides rulemaking authority, including for sanctions for violations of the provisions of this bill;

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▸ defines terms; and

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▸ makes technical and conforming changes.

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**Money Appropriated in this Bill:**

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None

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**Other Special Clauses:**

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None

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**Utah Code Sections Affected:**

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ENACTS:

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**26B-3-1201**, Utah Code Annotated 1953

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**26B-3-1202**, Utah Code Annotated 1953

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**26B-3-1203**, Utah Code Annotated 1953

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

Section 1. Section **26B-3-1201** is enacted to read:

**Part 12. Managed Care Transparency**

**26B-3-1201 . Definitions.**

As used in this part:

- (1) "Agent" means a person that has express or implied authority to obligate or act on behalf of another person.
- (2) "Affiliated person" means:
- (a) a subcontractor, subsidiary, or parent organization of a risk contractor; or
  - (b) a party with a substantial relationship to a risk contractor, including:
    - (i) an officer, director, trustee, general partner, managing employee, or other individual who holds a similar position of authority or responsibility, whether through employment or by contract;
    - (ii) a shareholder, member, or equity holder that owns, directly or indirectly, 5% or more of any class of equity interest, or any person who would own that interest upon conversion, exercise, or exchange of a convertible security, option, warrant, or similar instrument;
    - (iii) a risk contractor's key employee;
    - (iv) an immediate family member of a person described in Subsections (2)(b)(i) through (iii);
    - (v) an entity in which a person described in Subsection (2)(b)(i) through (iv) has an ownership interest of 5% or more, or for which an individual described in Subsections (2)(b)(i) through (iv) serves as an officer, director, or key employee;  
or
    - (vi) a person acting on behalf of, in concert with, or as an agent of a risk contractor with respect to:
      - (A) any duties, functions, activities, or decision-making under the risk contractor's contract with the department; or
      - (B) compliance with state or federal laws, regulations, or guidance.
- (3) "Claim" means a request or demand for payment for a service provided to an enrollee.
- (4) "Conflict of interest" means a circumstance or appearance of a circumstance where an interest in, or arising from, an arrangement, relationship, transaction, or activity could or does adversely affect a risk contractor's ability to, as viewed by a reasonable person with

- 63 knowledge of the relevant facts:
- 64 (a) diligently, effectively, and efficiently perform the risk contractor's duties and
- 65 responsibilities under the risk contractor's contract with the department;
- 66 (b) comply with federal and state law; or
- 67 (c) act impartially and in the best interest of the Medicaid program, taxpayers, and
- 68 Medicaid enrollees.
- 69 (5) "Control" means a person's authority or significant influence over another person's:
- 70 (a) decisions;
- 71 (b) governance;
- 72 (c) management;
- 73 (d) operations;
- 74 (e) finances;
- 75 (f) policies;
- 76 (g) business arrangements;
- 77 (h) staffing;
- 78 (i) Medicaid participation or contracts; or
- 79 (j) compliance with federal and state law.
- 80 (6) "Covered service" means a health or medical service or benefit covered through the
- 81 Medicaid program.
- 82 (7) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub.
- 83 L. No. 104-191, 110 Stat. 1936, as amended.
- 84 (8) "Immediate family member" means the same as that term, or the term member of
- 85 household, is defined in 42 C.F.R. Sec. 1001.2.
- 86 (9) "Improper payment" means:
- 87 (a) a payment:
- 88 (i) the state makes to a risk contractor in error, or in excess;
- 89 (ii) a risk contractor makes, or another person makes on behalf of a risk contractor:
- 90 (A) that should not be made;
- 91 (B) that is made in an incorrect or duplicate amount;
- 92 (C) that is inconsistent with the risk contractor's contract with the department,
- 93 applicable federal and state law, evidence-based clinical guidelines the division
- 94 approves, generally accepted accounting principles, or guidance issued by the
- 95 division;
- 96 (D) to or on behalf of a Medicaid provider, or the Medicaid provider's affiliated

- 97                    person, agent, or subcontractor who was deceased on the date the cost was  
98                    accrued; or
- 99                    (E) for a covered service that is:
- 100                    (I) for an individual who, on the date of service, was deceased or incarcerated;  
101                    (II) not a Medicaid-covered service within the scope of the risk contractor's  
102                    contract;  
103                    (III) not received by the intended individual as indicated on the claim;  
104                    (IV) not medically necessary;  
105                    (V) in a setting or place of service contrary to the Medicaid program;  
106                    (VI) not clearly, accurately, and sufficiently supported by the medical record of  
107                    the individual receiving the covered service; or  
108                    (VII) not supported by a clean claim that is complete, accurate, timely,  
109                    properly coded and formatted, and submitted consistent with applicable  
110                    claims standards and billing instructions; or
- 111                    (iii) made to a Medicaid provider under a sub-capitation or risk-sharing arrangement  
112                    where the Medicaid provider failed to submit timely, complete, and accurate data  
113                    necessary to support encounter data reporting;
- 114                    (iv) made to a Medicaid provider that, on the date of service:
- 115                    (A) was not properly enrolled or certified to participate in the Medicaid program;  
116                    (B) did not have a valid Medicaid provider agreement; or  
117                    (C) was not certified as meeting applicable requirements or conditions of  
118                    participation; or
- 119                    (v) made to a Medicaid provider for a covered service associated with missing,  
120                    incomplete, erroneous, or unvalidated encounter data;
- 121                    (b) a cost or expense a risk contractor, or risk contractor's subcontractor or agent on the  
122                    risk contractor's behalf, incurs:
- 123                    (i) in error;  
124                    (ii) by omission;  
125                    (iii) as a result of a deficiency in:
- 126                    (A) claims adjudication;  
127                    (B) accounting systems and procedures;  
128                    (C) internal controls over financial reporting;  
129                    (D) information systems; or  
130                    (E) electronic data interchange with Medicaid providers; or

- 131           (iv) as a result of incomplete or inadequate adherence to generally accepted  
132           accounting principles;
- 133       (c) a payment, incurred expense, transfer, or other transaction for which an independent  
134       auditor, the inspector general, or the department determines, consistent with generally  
135       accepted accounting principles and generally accepted auditing standards, that:
- 136           (i) a risk contractor lacks sufficient audit evidence; or  
137           (ii) financial information about the payment, expense, transfer, or transaction is  
138           misrepresented, misstated, unreliable, falsified, erroneous, incomplete, or missing,  
139           regardless of the pervasiveness or materiality to the risk contractor's financial  
140           statements or financial position;
- 141       (d)(i) a risk contractor's payment, incurred expense, transfer, or transaction during the  
142       period covered by an independent auditor's adverse opinion; or
- 143           (ii) the payments, expenses, transfers, and transactions an independent auditor who  
144           gives an adverse opinion, in consultation with the state Medicaid director, is able  
145           to reasonably determine resulted in the adverse opinion;
- 146       (e) if an independent auditor issues a disclaimer of opinion, all payments made,  
147       expenses incurred, transfers, and transactions of a risk contractor during the intended  
148       period of the uncompleted or prevented audit, unless, no more than 60 days after the  
149       date on which the independent auditor issues the disclaimer:
- 150           (i) all impediments to the performance of an independent audit are eliminated to the  
151           satisfaction of the independent auditor and the Medicaid director;
- 152           (ii) the independent auditor conducts and completes a full, independent audit  
153           consistent with generally accepted auditing standards; and
- 154           (iii) the independent auditor issues a complete audit report with a qualified or  
155           unqualified opinion;
- 156       (f) a payment, expense incurred, transfer, or transaction incident to or contributing to,  
157       directly or indirectly, the exceptions or qualified matters identified in an independent  
158       auditor's qualified opinion;
- 159       (g) a payment, incurred expense, transfer, or transaction made as a result, in whole or in  
160       part, of a conflict of interest;
- 161       (h) the excess amount of a payment that a Medicaid provider makes to a related party as  
162       a result of higher rates, favorable reimbursement policies or practices, financial  
163       incentives, more favorable terms and conditions, a preference in medical and  
164       utilization management practices, or preferences in market shares;

- 165 (i) a payment made:
- 166 (i) for goods or services, or intracompany or intercompany services, determined on
- 167 any basis other than or higher than a market-competitive, arm's length
- 168 arrangement, with no financial favoritism; and
- 169 (ii) by or on behalf of a risk contractor for the risk contractor's:
- 170 (A) parent organization;
- 171 (B) subcontractor;
- 172 (C) supplier;
- 173 (D) manufacturer;
- 174 (E) distributor; or
- 175 (F) vendor; or
- 176 (j) a payment made to, or for the costs of, a person listed in:
- 177 (i) the United States Department of Health and Human Services' Office of Inspector
- 178 General's List of Excluded Individuals/Entities;
- 179 (ii) the CMS National Plan and Provider Enumeration System exclusion list;
- 180 (iii) the United States Social Security Administration death master file;
- 181 (iv) exclusions or disqualifications from the General Services Administration's
- 182 System for Award Management; or
- 183 (v) another database described in:
- 184 (A) an agreement between the division and a managed care organization to
- 185 provide goods and services in the Medicaid program; or
- 186 (B) federal or state law or regulations.
- 187 (10) "Inspector general" means the inspector general of Medicaid services appointed under
- 188 Section 63A-13-201.
- 189 (11) "Key employee" means an employee with authority over:
- 190 (a) clinical operations;
- 191 (b) medical management;
- 192 (c) compliance;
- 193 (d) reporting;
- 194 (e) program integrity;
- 195 (f) contracting;
- 196 (g) network management;
- 197 (h) claims processing;
- 198 (i) utilization review;

- 199 (j) financial management;  
200 (k) Medicaid provider relations;  
201 (l) government relations; or  
202 (m) any other function material to the administration of a Medicaid risk contract.
- 203 (12) "Managed care organization" means a comprehensive full risk managed care delivery  
204 system that contracts with the Medicaid program or the Children's Health Insurance  
205 Program to deliver health care through a managed care plan.
- 206 (13) "Managed care plan" means a risk-based delivery service model authorized by Section  
207 26B-3-202 and administered by a managed care organization.
- 208 (14) "Managing employee" means an individual who:  
209 (a) exercises operational or managerial control over the employing entity's functions,  
210 activities, or units; or  
211 (b) directly or indirectly conducts the employing entity's day-to-day operations,  
212 functions, activities, or units.
- 213 (15) "Medicaid provider" means a person that furnishes, delivers, supplies, produces,  
214 orders, prescribes, administers, or dispenses a covered service.
- 215 (16) "National drug code identifier" means the same as that term is defined in 21 C.F.R.  
216 Sec. 207.33.
- 217 (17) "Ownership interest" means possession of, in an entity:  
218 (a) legal or beneficial ownership;  
219 (b) capital interest;  
220 (c) profit interest;  
221 (d) controlling interest;  
222 (e) any combination of the interests described in Subsections (17)(a) through (d);  
223 (f) indirect interest through another entity that has an interest described in Subsections  
224 (17)(a) through (d) in the entity; or  
225 (g) the right to acquire an interest described in Subsections (17)(a) through (d) in the  
226 entity upon conversion, exercise, or exchange of a convertible security, option,  
227 warrant, or similar instrument.
- 228 (18) "Parent organization" means an entity that, directly or indirectly, has a majority or  
229 greater ownership interest in and control of another entity.
- 230 (19) "Pass through payment" means the same as that term is defined in 42 C.F.R. Sec. 438.
- 231 (20) "Protected health information" means the same as that term is defined in 45 C.F.R.  
232 Sec. 160.103.

- 233 (21) "Related party" means:
- 234 (a) a risk contractor's parent organization;
- 235 (b) the subordinate holding company, subsidiary, agent, instrumentality, partnership,
- 236 joint venture, affiliated person, or subordinate business unit of:
- 237 (i) a risk contractor;
- 238 (ii) a risk contractor's parent organization;
- 239 (iii) a subcontractor;
- 240 (iv) a risk contractor's agent; or
- 241 (v) a Medicaid provider that is an entity described in Subsections (21)(a), (b)(i)
- 242 through (iv), (c)(i) through (iv), (d)(i) through (iv), (e)(i) through (iv), Subsection
- 243 (21)(f), or Subsection (21)(g);
- 244 (c) an entity that controls, is controlled by, or is in common control with:
- 245 (i) a risk contractor;
- 246 (ii) a risk contractor's parent organization;
- 247 (iii) a subcontractor;
- 248 (iv) a risk contractor's agent; or
- 249 (v) a Medicaid provider that is an entity described in Subsections (21)(a), (b)(i)
- 250 through (iv), (c)(i) through (iv), (d)(i) through (iv), (e)(i) through (iv), Subsection
- 251 (21)(f), or Subsection (21)(g);
- 252 (d) an entity that, directly or indirectly, has an ownership interest in:
- 253 (i) a risk contractor;
- 254 (ii) a risk contractor's parent organization;
- 255 (iii) a subcontractor;
- 256 (iv) a risk contractor's agent; or
- 257 (v) a Medicaid provider that is an entity described in Subsections (21)(a), (b)(i)
- 258 through (iv), (c)(i) through (iv), (d)(i) through (iv), (e)(i) through (iv), Subsection
- 259 (21)(f), or Subsection (21)(g);
- 260 (e) a Medicaid provider that, directly or indirectly, has an ownership interest in:
- 261 (i) a risk contractor;
- 262 (ii) a risk contractor's parent organization;
- 263 (iii) a subcontractor;
- 264 (iv) a risk contractor's agent; or
- 265 (v) a Medicaid provider that is an entity described in Subsections (21)(a), (b)(i)
- 266 through (iv), (c)(i) through (iv), (d)(i) through (iv), (e)(i) through (iv), Subsection

- 267                   (21)(f), or Subsection (21)(g);
- 268           (f) a Medicaid provider with a sub-capitation, risk-sharing, or shared-savings payment
- 269                   arrangement with a risk contractor; or
- 270           (g) an entity described in Subsections (21)(a) through (f) that is identified in:
- 271                   (i) disclosures;
- 272                   (ii) financial statements;
- 273                   (iii) an audit;
- 274                   (iv) regulatory filings;
- 275                   (v) administrative proceedings;
- 276                   (vi) court proceedings;
- 277                   (vii) federal or state:
- 278                           (A) oversight activities;
- 279                           (B) compliance activities;
- 280                           (C) enforcement activities; or
- 281                           (D) investigative activities; or
- 282                   (viii) state legislative oversight activities.
- 283           (22) "Risk contractor" means a person that has, or is seeking to qualify for, a contract with
- 284                   the department to provide or arrange for covered services to Medicaid program enrollees
- 285                   as:
- 286                   (a) a managed care organization;
- 287                   (b) a health insuring organization, a prepaid ambulatory health plan, or prepaid inpatient
- 288                           health plan, as those terms are defined in 42 C.F.R. Sec. 438.2;
- 289                   (c) a highly integrated dual eligible special needs plan or a fully integrated dual eligible
- 290                           special needs plan, as those terms are defined in 42 C.F.R. Sec. 422.2; or
- 291                   (d) another type of state-licensed risk-bearing entity that:
- 292                           (i) meets federal and state statutory and regulatory requirements;
- 293                           (ii) assumes full, partial, or shared risk for the cost of covered services; and
- 294                           (iii) may incur loss if the cost of providing the covered services exceeds payments
- 295                                   under the entity's agreement with the division to provide goods or services under
- 296                                   the Medicaid program.
- 297           (23) "State directed payment" means a contract arrangement that directs the expenditures of
- 298                   a managed care organization, including to implement value-based purchasing models for:
- 299                   (a) Medicaid provider reimbursement;
- 300                   (b) multi-payer reform;

- 301 (c) Medicaid-specific delivery system reform; or  
302 (d) performance improvement incentives, which may include, for Medicaid providers  
303 that provide a specific service under the agreement:  
304 (i) a minimum fee schedule;  
305 (ii) a uniform dollar amount or percentage increase in reimbursement; or  
306 (iii) a maximum fee schedule.
- 307 (24) "Subcontractor" means a person that contracts with a risk contractor to provide,  
308 arrange for, manage, or perform a good or service under the risk contractor's agreement  
309 with the division, including:  
310 (a) a pharmacy benefit manager;  
311 (b) a behavioral health organization;  
312 (c) a dental benefit administrator;  
313 (d) a transportation broker;  
314 (e) a utilization management organization; or  
315 (f) an entity that performs:  
316 (i) financial management services;  
317 (ii) claims processing;  
318 (iii) decision support and analytics;  
319 (iv) care management;  
320 (v) medical policy and utilization review services;  
321 (vi) quality improvement activities;  
322 (vii) provider network management;  
323 (viii) member services;  
324 (ix) information systems and technology services;  
325 (x) marketing;  
326 (xi) staffing services; or  
327 (xii) government relations.
- 328 (25) "Value add benefits" means benefits offered by a managed care organization in  
329 addition to standard coverage offered through the Medicaid program.
- 330 (26) "Value-based purchasing model" means a model for Medicaid provider reimbursement  
331 that recognizes value or outcomes over volume of services, including:  
332 (a) pay for performance; or  
333 (b) bundled payments.
- 334 Section 2. Section **26B-3-1202** is enacted to read:

335           **26B-3-1202 . Medicaid managed care quality data -- Dashboard-- Reporting**  
336 **requirements -- Rulemaking authority.**

337 (1)(a) By July 1, 2026, the division shall establish and maintain a dashboard to report the  
338 data described in this Subsection (1) that is:

339           (i) online on the division's website;

340           (ii) easily accessible to the public through a link posted in a conspicuous place on the  
341 division's website;

342           (iii) organized by managed care plan;

343           (iv) searchable;

344           (v) machine readable; and

345           (vi) able to be downloaded or printed.

346 (b) For each managed care plan, the division shall publish and quarterly update on the  
347 dashboard described in Subsection (1)(a), the following data:

348           (i) the total count of services rendered, by billing code type, Medicaid provider type,  
349 and care setting;

350           (ii) total spending on medical claims, non-claims expenditures, and non-benefit  
351 services by managed care organization;

352           (iii) total spending on pass through payments and state directed payments by facility;

353           (iv) total spending:

354                   (A) by billing code type;

355                   (B) by Medicaid provider type, including public and private Medicaid providers,  
356 and care setting type;

357                   (C) on mandatory Medicaid benefits; and

358                   (D) on optional Medicaid benefits, including value add benefits;

359           (v) total number and share of enrollees receiving care in an emergency room;

360           (vi) total claims and spending on services delivered in an emergency room;

361           (vii) total spending on services delivered by a subcontractor or managed care  
362 organization's related party, by service type;

363           (viii) total spending on prescription drugs by active ingredient; and

364           (ix) total number and share of enrollees for whom no claims were filed.

365 (c) When publishing the data described in Subsection (1)(b)(iv), the division shall  
366 identify whether the source of funding for the reported spending is federal or state  
367 funds.

368 (d) The division may use existing databases or other tools to fulfill the requirements of

- 369           this Subsection (1).
- 370           (e) By December 31, 2026, the dashboard shall include, in addition to the quarterly  
371           updated data from July 1, 2026, through December 31, 2026, the data described in  
372           Subsection (1)(b) from January 1, 2023, through July 1, 2026.
- 373           (2)(a) A managed care organization shall submit to the division complete copies of all  
374           data, reports, and disclosures the managed care organization submits to CMS related  
375           to the managed care organization's participation in the Medicaid program no later  
376           than 30 days after the day on which the managed care organization submits the data,  
377           report, or disclosure to CMS.
- 378           (b) No later than 30 days after the day on which the division receives a submission  
379           described in Subsection (2)(a), the division shall post the submission on the division's  
380           website:
- 381           (i) in a format that is searchable and machine readable; and
- 382           (ii) through a link that is easily accessible to the public and posted in a conspicuous  
383           place on the division's website.
- 384           (c) The division shall redact protected health information from a submission before  
385           posting the submission on the division's website as described in Subsection (2)(b).
- 386           (3) A managed care organization shall certify in writing that the data, reports, and  
387           disclosures the managed care organization submits to the division under Subsection (2)  
388           are accurate and complete.
- 389           (4) The department shall require that each managed care contract includes a provision that  
390           requires a managed care plan to comply with this section and rules the department  
391           makes under this section, subject to sanctions provided in accordance with Section  
392           26B-3-108.
- 393           (5) If the division, under rules made by the department in accordance with Section  
394           26B-3-108, or the federal government, sanctions a managed care organization with  
395           termination from the Medicaid program, the managed care organization is not eligible to  
396           enter into a new contract with the department:
- 397           (a) until five years after the date on which the managed care organization was  
398           terminated; and
- 399           (b) unless the managed care organization submits to the department a written  
400           explanation of action the managed care organization has taken to ensure the managed  
401           care organization's compliance with this section.
- 402           (6)(a) The division shall annually publish a report that includes a summary of, and

- 403 managed care organization-specific measures of, managed care organizations'  
404 financial performance and service utilization.
- 405 (b) The division shall annually submit the report described in Subsection (6)(a), on or  
406 before November 1 each year, to the Health and Human Services Interim Committee  
407 and the Social Services Appropriations Committee.
- 408 (7)(a) The division shall make publicly available on the division's website:
- 409 (i) the data described in Subsection (1) in the dashboard described in Subsection  
410 (1)(a);
- 411 (ii) medical loss ratio audited reports; and
- 412 (iii) the report described in Subsection (6).
- 413 (b) The division shall ensure that data that is published as described in this section,  
414 including financial data and data described in Subsection (1), is deidentified.
- 415 (8)(a) Unless otherwise provided by applicable state or federal law, a submission a  
416 managed care organization submits to the division in accordance with this section is a  
417 public record under Title 63G, Chapter 2, Government Records Access and  
418 Management Act.
- 419 (b) Except as provided in Subsection (8)(c), a risk contractor, subcontractor, or an  
420 affiliated person of the risk contractor or subcontractor, may not make a claim of  
421 business confidentiality under Section 63G-2-309 for any data, information, report, or  
422 disclosure submitted to the division under this section.
- 423 (c) Subsection (8)(b) does not apply to commercial information or nonindividual  
424 financial information described in Subsection 63G-2-305(2).
- 425 (d) If a person described in Subsection (8)(b) makes a claim of business confidentiality  
426 in accordance with Subsection 63G-2-305(2) as described in Subsection (8)(c), the  
427 division shall redact the information that is subject to the claim of business  
428 confidentiality before publishing, posting, or otherwise making the submission public.
- 429 (9) Nothing in this section shall be construed to alter or preempt the requirements for  
430 protecting health information under HIPAA.
- 431 (10) The department shall make rules in accordance with Title 63G, Chapter 3, Utah  
432 Administrative Rulemaking Act, to implement this section.
- 433 Section 3. Section **26B-3-1203** is enacted to read:
- 434 **26B-3-1203 . Identifying improper payments -- Repayment -- Prevention.**
- 435 (1) Each risk contractor and subcontractor shall quarterly:
- 436 (a) identify and document all improper payments;

- 437 (b) conduct a root cause analysis for each type of improper payment;
- 438 (c) repay all improper payments that are due to the Medicaid program no later than 30
- 439 days after the day on which the report described in Subsection (2) is due; and
- 440 (d) develop and implement a corrective action plan that includes improvements in
- 441 policies, procedures, accounting, financial management, internal controls,
- 442 information systems, reporting, staffing, or training necessary to address improper
- 443 payments.
- 444 (2)(a) Each risk contractor and subcontractor shall quarterly submit to the division a
- 445 report of the risk contractor's or subcontractor's improper payments, root cause
- 446 analyses, and corrective action plan.
- 447 (b) The department shall publish the reports described in Subsection (2)(a) on the
- 448 department's website.
- 449 (3) The department shall make rules in accordance with Title 63G, Chapter 3, Utah
- 450 Administrative Rulemaking Act, to establish:
- 451 (a) due dates for the submission of reports described in Subsection (2); and
- 452 (b) sanctions for a risk contractor's or subcontractor's failure to repay as described in
- 453 Subsection (1)(c), consistent with Section 26B-3-108.

454 Section 4. **Effective Date.**

455 This bill takes effect on May 6, 2026.